THE USE OF OUTCOME MEASURES BY LICENSED MARRIAGE AND FAMILY THERAPISTS IN IOWA

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by Kevin Patrick Carroll

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An abstract of a Dissertation by
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Problem: In recent decades there has been growing concern about the ability of mental healthcare services to demonstrate their value. The primary purpose of this quantitative study is to advance the client-focused research paradigm for improving quality and efficiency in the provision of psychotherapy services by investigating the use of outcomes measures by Licensed Marriage and Family Therapists (LMFTs) in Iowa. Secondary purposes of the study are to collect basic demographic and practice data on LMFTs in Iowa and to examine the relationships between LMFTs' use of outcome measures and demographic and practice variables.

Procedures: Paper surveys were mailed to all 174 LMFTs in the state of Iowa. Addresses were obtained from the Iowa Department of Public Health's Bureau of Professional Licensure. A self-report survey instrument, LMFT Outcomes Survey, was created for this study. An initial mailing with cover letter and survey was followed up with a reminder postcard sent two weeks later. A 52.3% response rate was achieved.

Findings: Sixty-four percent of the active therapists in the sample reported utilizing 80 different outcome measures with 70% of their clients to assist in assessing client outcomes. Five percent of active therapists report continuous use of outcome measures in routine practice, with Partners for Change Outcome Management System's Outcome Rating Scale and Session Rating Scale outcome measures being utilized the most. No significant relationships were found among demographic and practice variables and LMFTs' use of outcomes measures.

Future Research: While therapists are using outcome measures consistently, they are not using them with every client over the course of treatment. Future research questions could include: (a) What is occurring with the clients/cases for whom outcome measures are not utilized? and (b) more clinically focused questions, such as, How is the use of outcome measures aiding the client? Additionally, exploring therapist training received in master's degree programs or in on-going supervision settings and examining workplace requirements could yield useful information, illuminate current practice, and perhaps accelerate the adoption of a scientific-practitioner mindset with regard to measuring outcomes.

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Chapter 1

INTRODUCTION

Mental health researchers have known for three-quarters of a century that psychotherapy can be effective (Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). Yet in the past 20 years, a diverse collection of constituents have scrutinized psychotherapy services, offered serious critiques, and made calls for reform. Specifically, concerns about large client dropout rates, lack of scientific rigor, and therapists' attitudes (e.g., overconfidence) and skills (e.g., poor prediction of client outcomes) have resulted in calls for accountability and change.

In response to the criticism, researchers of mental health services have employed three research traditions in an attempt to shore up and improve research and practice that demonstrate psychotherapy's effectiveness (Lambert, 2001). One research paradigm, client-focused research, has yielded results indicating that utilizing outcome measures to capture improvement data of individual clients addresses the criticisms (Howard, Moras, Brill, Martinovich, & Lutz, 1996). Despite the promising research, little is known about the actual use of outcome measures with Licensed Marriage and Family Therapists (LMFTs), and little is known about the use of outcome measures by LMFTs in Iowa.

Therapy Works

The mental health treatment called psychotherapy, or therapy, has repeatedly demonstrated effectiveness (Lambert & Ogles, 2004; Wampold, 2001; Shadish, Ragsdale, Glaser, & Montgomery, 1995). Research on therapy outcomes has shown that therapy services can be effective for some clients some of the time (Anker, Duncan, & Sparks, 2009). Since the 1930s, research on the results of psychotherapy has consistently

shown the treatment to be generally positive (Lambert et al., 2005). The efficacy of psychotherapy is good; the average person receiving psychotherapy treatment is better off than about 80% of the untreated sample (Duncan, Miller, Wampold, & Hubble, 2010). In statistical terms, this translates to an effect size of about 0.8. In addition to researchers' claims on the clinical outcomes of psychotherapy, the largest (N = 4,000) in-depth survey of consumers of mental health care (Mental Health, 1995) provided convincing evidence that therapy can make an important difference in peoples' lives.

Growing Concerns

While the overall message is that psychotherapy can and does work, the reality is that for many clients it does not result in a positive outcome (Mohr, 1995). Approximately five to ten percent of clients deteriorate in therapy and 35-40% show no measurable improvement (Newnham, Harwood, & Page, 2007; Hansen, Lambert, & Forman, 2002). Specific concerns about psychotherapy, raised by multiple stakeholders, include: large client dropout rates (Sharf, 2007), lack of scientific rigor (Asay, Lambert, Gregersen, & Goates, 2002), and indications that therapists are blind to many of these issues by being poor predictors of who is at risk while being overconfident about their service (Hannan et al., 2005), all of which have led to calls for accountability and reform.

Dropouts. Wierzbicki and Pekarik (1993) conducted a meta-analysis of 125 studies on psychotherapy dropout resulting in a mean dropout rate of 46.86%. The reviewed studies defined *dropout* in multiple ways, and rates differed by definition, thus reducing the overall clarity of the interpretation of the mean dropout rate. Nonetheless, the researchers highlighted multiple problems associated with premature termination, including most importantly, reduced treatment efficacy and decreased cost-effectiveness.

Sharf (2007) more recently conducted a meta-analytic study on psychotherapy dropout rates building on Wierzbicki and Pekarik's (1993) work. Results indicated a 35.26% average dropout rate across 110 studies, which is less than Wierzbicki and Pekarik's 46.86%. Although for this study rates did not differ by definition of dropout, rates did vary significantly according to the country of study, study design, and primary diagnosis..

Sharf (2007) also investigated why clients drop out, finding the following factors as moderately strong predictors of premature termination: therapeutic alliance, treatment expectations, client motivation, client self-efficacy, client hostility, and client impulsivity. Variables less strongly predictive of dropout rate were: symptom severity and diagnosis, treatment length, treatment type, and therapist training.

For multiple reasons too many clients do not stick with therapy long enough to experience a positive outcome (Bickman, 2008). Dropouts, depending on the definition, can comprise 30-60% of a therapist's caseload and cause considerable concern for therapists, payers, and consumers. Duncan and Miller (2008) estimate that nearly 50% of clients drop out. Further, they point out that many outcome studies omit data on participants who drop out of research projects which may artificially inflate effectiveness numbers. For example, Hansen et al. (2002), while using a national database of 9,173 clients, discovered that 33% of clients only attended one session of therapy. The research continued with the remaining 6,072 clients and found that 23% of those who attended two or more sessions "improved" or "recovered." This computes to only 15% of clients who began therapy showing measurable signs of improvement (Hansen et al., 2002). This

is a somber picture of routine psychotherapy practice. Dropouts are a serious problem in the delivery of mental health services.

Lack of scientific rigor. There is a long-standing gap between psychotherapy research and practice that has been of increasing concern (Asay et al., 2002). The gap exists for many reasons, foremost of which is the perceived lack of relevance of academic researchers' results to the real world of full-time therapists. This historical context has produced a drift away from research and toward increased supervision and case consultation in clinical practice (Asay et al., 2002). While mental health researchers have been busy the past 30 years developing and refining standardized measures to assess psychotherapy outcome, therapists have generally paid scant attention to the developments (Hatfield & Ogles, 2004; Phelps, Eisman, & Kohout, 1998).

Recent national attention in the popular press and media has highlighted differences in mental health professionals' views on science. *Newsweek* magazine, in an article titled, "Ignoring the Evidence: Why do Psychologists Reject Science?" (Begley, 2009), highlighted a disagreement among psychologists. The author, writing to a large American audience, articulated a viewpoint of a minority of psychologists who believe too many therapists give more weight to their personal experiences than to scientific, evidence-based treatments. "The disconnect between what therapists do and what science has discovered is an unconscionable embarrassment" (para. 1). A more accurate and nuanced rebuttal to the *Newsweek* article, written and published by the American Psychological Association (APA) (Breckler, 2010), was undoubtedly read by a fraction of the *Newsweek* audience. Three months later, an article in the *LA Times* (Jaffe, 2010) picked up the same theme, reporting that psychologists are not looking to research or

science to inform their practices. Finally, the popular NPR program, *Science Friday* (2009, December 4), held a lively debate among psychologists entitled, "Can Science Make Psychotherapy More Effective?" These recent stories in the media highlight what has been known to those in the field for some time; e.g., there is a profound disconnect between the best of science and what routinely occurs in psychotherapy practice. This is evident in many areas of practice including the therapists' acceptance and implementation of outcome measures.

Therapists as poor predictors yet overconfident. Of central importance in improving psychotherapeutic outcomes is identification of clients who are not improving. In routine practice there are two groups of people who are involved in making such a determination, clients and therapists. Hannan et al. (2005) found that therapists ($N = 40$) seldom accurately predict which clients will worsen or are worsening in therapy. Moreover, even very effective therapists seem to be poor at identifying deteriorating clients. In their study, Hannan et al. (2005) compared therapist predictions of client deterioration to actuarial methods. Though therapists were aware of the study's purpose, familiar with the outcome measure used, and informed of the expected rate of client declining at 8%, they predicted deterioration in only one of 550 cases. Therapists identified only one out of 40 clients who had deteriorated. In contrast, the actuarial method correctly predicted decline in 36 of the 40 clients. Such findings indicate that outcome measures based on mathematical modeling hold promise for overcoming the inherent biases of therapists' estimations. Friedman (2007) stated, "The clear implication is that therapists are not always the best judge of how their clients are doing" (para. 15). Sapyta, Riemer, and Bickman (2005) note the traditional methods for training and

improving effectiveness of therapists are education, internship, and supervision; yet, research does not indicate that any of these time-honored traditions necessarily work at improving effectiveness (Bickman, 2008).

While therapists may be poor predictors of deterioration (Breslin, Sobell, Buchan, & Cunningham, 1997; Sapyta et al., 2005), research also suggests that perceptions of clients and therapists often differ when it comes to evaluating the effectiveness of services (Greenberg, Bornstein, Greenberg, & Fisher, 1992) with client perceptions being more accurate in predicting outcomes (Bachelor & Horvath, 1999; Kazdin, Marciano, & Whitley, 2005; Shirk & Karver, 2003). These studies suggest that efforts to monitor and measure outcomes should be collaborative but based primarily on the impressions and opinions of the clients (Orlinsky, Rønnestad, and Willutzki, 2004).

Researchers (Hannan et al., 2005) point to a larger issue: therapist overconfidence. In Dew and Riemer's (2003) study, 67% of therapists ($N = 143$) graded gave themselves an "A" on their effectiveness. None of the therapists graded themselves below average. Hiatt and Hargrave (1995) found that the least effective therapists believed they were as helpful as the most effective therapists. These results provided a context for understanding why therapists may be disinclined to think they need to use outcome measures or that they should privilege the client's perspective in evaluating the effectiveness of the service.

In an interview reported in *Psychotherapy Networker* (2009) Duncan and Sparks, advocates for routine use of outcome measures completed by clients, were asked why more therapists do not incorporate simple outcome measures. The two researchers stated that many therapists believe they collect such data informally but that few of them

actually do. Lambert et al. (2005) concluded that despite therapists' confidence in their own ability to predict client outcome, therapists should adopt practices to measure, monitor, and predict treatment failure, thereby enhancing treatment outcomes for clients.

Calls for accountability. Given the research results documenting the concerns over dropouts, lack of scientific rigor, and overconfident therapists as poor predicators of outcomes, numerous mental health stakeholders have made calls for reform and accountability in the provision of psychotherapy services. In 1996, Rainer proclaimed, "We have entered into an age of accountability for the provision of psychotherapy services" (p.159) and claimed that the paradigm of the health care environment had shifted to a cost effective focus. Mental health professionals were challenged to demonstrate the full value of psychotherapy. Due to the accountability demands from policymakers and the marketplace, two years later, Phelps et al., (1998) urged therapists to make measurement of clinical outcomes a part of practice.

The marketplace exerts tremendous pressure on the delivery of services to customers; the commodity of psychotherapy is not exempt. Brown, Dreis, and Nace (1999) discussed the economic realities facing the purchasing and delivery of therapy services. Insurance companies, federal agencies representing Medicare and Medicaid, managed care organizations, and others demand data from therapists on the treatment they provide and the outcomes (Bickman et al., 2000). A large player in this arena is managed behavioral health care organizations (MBHCOs), which, in many instances, pay for services and serve as the connection between therapists and clients. The MBHCOs want to keep client costs down, but they also want effective services for their clients. They want to move away from the paradigm of paying a preset fee for a certain service (a

quantity based system) and toward a payment structure that rewards actual improvement of individual clients' health (a quality based system) (Brown & Jones, 2005). In other words, they do not want to pay for an ineffective service that cannot or does not demonstrate its value. One way MBHCOs attempt to achieve these goals is by gathering and analyzing large amounts of data and comparing them to outcomes. However, meaningful client outcome data is frequently non-existent in routine clinical practice, and therapists are limited to relying on their own judgment in making claims of effectiveness. Unsatisfied with the status quo, large MBHCOs, such as Human Affairs International (HAI) and PacifiCare Behavioral Health, have launched outcome measurement initiatives with therapists to push the quality envelope (Brown et al., 1999; Brown et al., 2001; Brown & Jones, 2005). As a result, there has been a real and radical shifting in the business of psychotherapy, from simple reimbursement for services to compensation for clinical outcomes (Brown et al.,1999).

In 2001 the Steering Committee of APA's Division 29 (Psychotherapy) Task Force (Ackerman et al., 2001) produced a report with conclusions and recommendations. One Practice Recommendation by the Task Force was for practitioners to routinely monitor clients' responses to the therapy relationship and ongoing treatment. Two years later, The President's New Freedom Commission on Mental Health (2003) presented their report, *Achieving the Promise: Transforming Mental Health Care in America*. The members of the Commission sent President George W. Bush an update on the nation's mental health care systems and recommendations for improvement. One problem cited was the 15-20 years of lag time between the development of rigorously researched services and the actual implementation of those practices in routine care. This lag time

has been demonstrated in the reticent embracement of outcome measures by therapists in routine practice (Hatfield & Ogles, 2004; Phelps et al., 1998).

In 2005 Charles Curie, the Administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA) stated, "Increasingly, policymakers and budget planners at all levels – Federal, state, local and private – are basing funding decisions on outcome data" (para. 2). To achieve true accountability therapists were encouraged to utilize pre- and post-service comparisons to evaluate outcomes (SAMHSA, 2005). In the following year the APA (2006) defined evidence-based practice in psychology (EBPP) as "the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences" (p. 273). The APA Presidential Task Force on Evidence-Based Practice (2006) further defined clinical expertise to include monitoring of client progress.

Calls for reform from within the field have repeatedly been made with questionable impact. Bickman (2008) voiced his concern and frustration with the current state of affairs.

> The measurement of clinical outcomes has been possible for decades....In the last several years a small number of researchers have been fielding systems that provide not only measurement of progress but clinical feedback as well. Such systems...have not been greeted with much enthusiasm and support...even relatively simple outcome measurement is rarely used to evaluate the effectiveness of services. (p.438)

Bickman argued that continuing education, evidence based treatments, accreditation, licensing, and clinical judgment are generally accepted mechanisms to ensure quality of

care, yet none of these provides substantial evidence of improving client outcomes. Finally, commenting on the current state of affairs in community mental health and summarizing national reports, Bohanske and Franczak (2009) claimed the delivery of mental health services is oriented toward the requirements of bureaucracies and stakeholders. Furthermore, they claimed that for many organizations focusing on meeting administrative, process, and quality assurance measures takes precedence over clients having a voice in monitoring the effectiveness of their treatment.

Despite the overall effectiveness of psychotherapy, dropouts are a substantial problem, the role of science is in question, therapists are overconfident and poor judges of client deterioration. Repeated calls to the profession may be falling on deaf ears. From this context two research fronts have risen: treatment focused research and client-focused research. Both efforts attempt to improve the quality of care in the provision of psychotherapy services while addressing the core concerns previously mentioned.

Treatment Focused Research

Efficacy research. Mental health professionals from around the world have made attempts at improving the quality of services for clients receiving psychotherapy. Researchers have addressed this key issue facing the profession by advancing three different research paradigms (Howard et al., 1996; Lambert, 2001), two within the category of treatment focused research and the third within client-focused research. The first paradigm is referred to as efficacy research, and it takes place under special experimental conditions with control groups and randomization. This pure research is academically focused and lacks considerable applicability to the real world for most therapists. Efficacy research, or clinical trials research, typically compares the clinical

gains of a highly selected sample of clients who have participated in a specific psychotherapy treatment with a sample of clients receiving a competing treatment, no treatment, or placebo (Lambert, Hansen, & Finch, 2001; Shadish et al., 1995). The clinical trials frequently apply manualized and highly managed treatment delivered by trained therapists. Because these conditions are rarely found in routine practice, the external validity of the efficacy studies is questionable (Hansen et al., 2002). Efficacy research is considered a type of treatment focused research because the assumption of the researchers is that the effects of the specific treatments or interventions are what impact client improvement and are therefore important to study (Lambert, 2001).

Effectiveness research. The second research paradigm is called effectiveness research, and it attempts to demonstrate therapy's effectiveness in real-world or natural settings (Seligman, 1995). This research attempts to take the results of efficacy research into the world of every day practice (Howard et al., 1996). Effectiveness research evaluates the specific treatments found valuable in efficacy research but without the highly controlled settings (Shadish et al., 1995). Various methods of capturing improvement are reported in aggregate by researchers, with pronouncements such as, "In 2008, 75% of clients at ABC Counseling experienced a reduction in symptoms when XYZ treatment was utilized." Although administrators feel good they are collecting data, payers are pleased to receive general outcome data, and consumers find comfort in declarations of success, the data do not typically tell the whole story. Effectiveness research is limited by omitting dropouts from data sets, lack of experimental control, focusing on mean responses of aggregated data rather than individual client

improvement, and producing reports and feedback months after service has terminated (Lambert, 2001; Lambert, Hansen, & Finch, 2001).

Client-focused Research

Client-focused research (Howard et al., 1996) also known as practice based evidence (Barkham et al., 2001) or process research (Pinsof & Wynne, 2000), is the third and most recent research paradigm used to measure and improve psychotherapy services through the rigorous implementation of outcome measures. Researchers around the world have joined to develop research and practice methods to measure, monitor, and manage clients' progress in psychotherapy over time (Ogles, Lambert, & Fields, 2002). This research paradigm stands in contrast to efficacy research findings that are largely dismissed or ignored by practitioners since they are far removed from the day-to-day realities faced by therapists. Effectiveness research is more relevant to therapists, as it takes place in real-world, naturalistic settings; however, it focuses on the mean response of a group of clients and gives summary data typically weeks or months after service. Client-focused research endeavors to be relevant to individual therapists because of its emphasis on improving the outcome of the client currently in treatment (Lambert et al., 2002).

This approach asks the challenging questions: "I know this particular treatment can work, but is it working for this client? How do I know that the client sitting in front of me is actually improving?" This research ventures to improve psychotherapy outcome by bridging the gap between research and practice. This is accomplished through the ongoing monitoring of client change through the use of outcome measures and providing this information to therapists before termination to guide ongoing treatment (Lambert,

2001; Lambert et al., 2005; Whipple et al., 2003). Researchers in the client-focused research paradigm focus on a methodology that provides feedback through the use of outcome measures within the ongoing therapy, which ultimately leads to clinical benefits (Lambert, 2001).

Client-focused research has led to the growth of six well-developed outcome measurement systems, with more under development (Halstead, Leach, & Rust, 2007; Pinsof et al., 2009). The first system to track client change quantitatively was COMPASS (Howard et al., 1996). The research paradigm was further developed by Lambert and colleagues at Brigham Young University (Lambert et al., 1996). Their Outcome Questionnaire (OQ-45) is the most researched client-focused measure available (Lambert, 2009). Another system to assess client change is the Treatment Outcome Package (Kraus, Seligman, & Jordan, 2005). Researchers Miller et al. (2006) are the latest to develop a complex outcome measure system, Partners for Change Outcome Management System (PCOMS). Finally, two systems outside of the United States have been created, the Stuttgart-Heidelberg System (also known as AKQUASI) in Germany (Kordy, Hannover, & Richard, 2001), and the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) in the United Kingdom (Barkham et al., 2001).

In 2003 Lambert et al. posed a question to the field in their paper, "Is It Time for Therapists to Routinely Track Client Outcome?" After reviewing a meta-analysis across three studies of 2,500 clients, the researchers concluded that it "may be time for therapists routinely and formally to monitor client treatment response" (p. 288). Six years later, Lambert (2009) answered the question with a book chapter and call to the profession titled, *Yes, it is Time for Therapists to Routinely Monitor Treatment Outcome*. In addition

to therapists' regularly monitoring outcomes, it is time for researchers to examine who is doing what, how, and why, to identify obstacles to the dissemination and implementation of this best practice.

Purpose Statement

Psychotherapy can be effective, but its impact suffers from numerous concerns. Calls for accountability and reform for effective clinical services have been met with a trio of research paradigms with client-focused research demonstrating great promise (Ogles et al., 2002). Client-focused research has demonstrated the ability of therapists to use scientifically sound outcome measures to reduce dropouts, neutralize overconfidence and poor predictability, and generate improved outcomes in routine practice (Miller et al., 2006). However, the actual practices of therapists with respect to measuring psychotherapy outcome are relatively unknown and almost completely unknown with Licensed Marriage and Family Therapists (LMFTs). The purpose of the current research study is to explore the use of outcomes measures by LMFTs in Iowa because (a) little is known about the use of outcome measures by Iowa LMFTs, and (b) no data have been published about LMFTs engaged in client-focused research methodologies. In addition to collecting basic descriptive statistics on demographics, practices, and outcome variables, this study seeks to better understand the association among variables.

Research Hypotheses

Based on the literature review, gaps in the existing literature, and this researcher's clinical experience, this research study sought to expand knowledge by testing seven specific hypotheses and examining the demographic and practice patterns of LMFTs.

Hypothesis #1: A minority (less than 50%) of LMFTs utilize outcome measures to assist in assessing outcome.

Hypothesis #2: Of the LMFTs who use outcome measures, these measures are used with a minority of clients/cases.

Hypothesis #3: Over the course of treatment, the frequency with which outcome measures are most commonly used is one time.

Hypothesis #4: Continuous (at every session) measurement of outcome is practiced less than three percent of the time by Iowa LMFTs.

Hypothesis #5: A minority of Iowa LMFTs are aware of any of the sophisticated client-focused outcome systems.

Hypothesis #6: The reasons for using/not using outcome measures are similar to reasons given by psychologists on past surveys.

Hypothesis #7: Non-users of outcomes measures are significantly different demographically from users in terms of age, length of licensure, number of child/adolescent clients, and practice setting.

Finally, since this study is the most recent examination of the Iowa LMFT profession, demographic and practice data were examined.

Definition of Key Terms

AKQUASI – An outcome management system utilized primarily in Germany. Also known as the Stuttgart – Heidelberg System (Kordy et al., 2001).

APA – American Psychological Association.

Client-Focused Research – A type of research that endeavors to measure, monitor and manage client's progress over time. Also known as practice based evidence or process research (Ogles et al., 2002).

Clinical Outcomes in Routine Measurement – Outcome Measure (CORE-OM) – An outcome management system utilized primarily in the United Kingdom (Barkham et al., 2001).

COMPASS – The first outcome management system in the United States (Howard et al., 1996).

Effectiveness Research – The branch of treatment focused research that takes treatments developed in efficacy research and tests them in real world clinical settings (Seligman, 1995).

Efficacy Research – The branch of treatment focused research that utilizes experimental conditions, control groups, randomization. Also known as clinical trials research. (Shadish et al., 1995).

Feedback – Data generated by an outcome measure, typically shared with the therapist and sometimes the client.

LMFT – Licensed Marriage and Family Therapist.

Outcome Questionnaire 45 – The most researched outcome measure/system (Lambert et al., 1996)

Partners for Change Outcome Management System – The newest and briefest outcome measurement system, which utilizes two outcome measures the ORS and SRS (Miller et al., 2006).

Treatment Focused Research – A type of research that posits the effects of specific treatments are what impact client improvement and are therefore important to study (Lambert, 2001).

Treatment Outcome Package – An outcome management system (Kraus et al., 2005).

Summary

In sum, researchers have repeatedly demonstrated therapy can be effective, yet the field is often criticized for its inability to demonstrate real-world success. A trio of research paradigms has emerged to advance the scientific underpinnings of psychotherapy outcome measurement. Research on client-focused methodologies indicates promise for therapists and clients in measuring and improving outcomes, however, little is known about the use of these newer outcome measures and methodologies. This research study seeks to explore the use of outcome measures with LMFT professionals in Iowa.

Chapter 2

LITERATURE REVIEW

Client-focused research offers a new paradigm for researchers and practitioners focused on improving psychotherapy (Howard et al., 1996). It has led to the development of new measures and innovative methodologies to measure outcomes (Newnham, 2010). This newest version of outcome measurement in the United States and around the world has provided strong indications that such approaches are beneficial to clients, therapists, and payers of mental health services (Anker et al., 2009; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001, 2002; Reese, Norsworthy, & Rowlands, 2009; Slade et al., 2006; Schmidt et al., 2006; Whipple et al., 2003). However, no published survey research has documented routine utilization of client-focused research methodologies by therapists, including the subpopulation of Marriage and Family Therapists, the focus for this study. Survey research indicates that most therapists, regardless of discipline, do not regularly use simple outcome measures (Beaton, Dienhart, Schmidt, & Turner, 2009; Hatfield & Ogles, 2004; Johnson, Sandberg, & Miller, 1999; Phelps et al., 1998). There are data on who uses outcome measures, why they use them, what measures are used, and what information is valued (Hatfield & Ogles, 2007; Hatfield & Ogles, 2004; 2007). Finally, challenges to moving toward implementation of client-focused research methodologies are presented.

Client-focused Research

In the past half century the term "outcome measure" has come to encompass a diverse collection of tools, instruments, scales, assessments and inventories (Ogles et al., 2002). Outcome measures are ideally defined as "assessing the clinical outcome of

treatment through the use of standardized measures of clinical severity" (Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001, p. 925). These measures have been employed in a number of methodologies typically as a part of efficacy and effectiveness research generally aimed at measuring the effectiveness of a specific treatment or intervention (Lambert et al., 2001). Efficacy and effectiveness research represents the vast majority of published studies attempting to improve psychotherapy, including marriage and family therapy (Pinsof & Wynne, 1995). The research focus on improving the treatments and interventions utilized in therapy is laudable, however, client-focused research is a new movement to refine outcomes measurement and practice to look further than controlled studies, average group effects, and focus on individual client results (Newnham, 2010).

By evaluating outcomes data, client-focused outcome research has the expressed purpose of quantitatively tracking the progress of individual clients in therapy in an effort to improve the effectiveness of treatment services (Brown et al., 2001). Outcomes measures, delivered in this manner, provide stakeholders (therapists, clients, agency administrators, and payers) a common language for measuring change. Client-focused research offers a new approach to two old problems: How to measure success in psychotherapy, and how the mental health field can bridge the science and practice gap.

Six Current Systems.

COMPASS. Client-focused research has led to the growth of six sophisticated outcome measurement systems. Howard et al. (1996) presented the first client-focused outcome system, COMPASS. The outcome measure, comprised of 68 items, is divided into three subscales and takes approximately 15 minutes to complete. The three subscales

combine to form an overall Mental Health Index (MHI). Howard, Brill, Lueger, O'Mahoney, and Grissom (1993) determined the reliability of the MHI was .87 (internal consistency) and .62 (test-retest). Howard et al. (1996) helped pioneer the new research paradigm by advancing the foundational concept of client profiling in the COMPASS system. Using statistical techniques and dose-response research (Howard et al., 1986), the researchers found they could predict future outcome scores based on the client's initial score. This resulted in each client having a predicted course of treatment, which when coupled with monitoring, signaled when a client was not progressing as expected or was deteriorating. A Treatment Progress Report was generated for the therapist based on the scores of the client. Moving beyond therapists' gut instincts and their poor predictive powers (Hannan et al., 2005), the statistically based system allowed technology to create modeling based on dose and response to predict improvement across sessions (Leon, Kopta, Howard, & Lutz, 1999; Lueger et al., 2001).

Outcome Questionnaire. The Outcome Questionnaire (OQ or OQ-45 or OQ-45.2) is the second, and most widely known and researched brief self report instrument (Lambert et al., 2001, 2002). It was designed to be easy to use, inexpensive, and accurate while measuring three domains: symptomatic distress, interpersonal relations, and social role functioning. Clients rate their feelings on a five-point Likert scale ranging from 0-4 on the 45 item instrument. Scores can range from 0-180, with higher scores indicating higher distress (Lambert et al., 1996). Additionally, scoring is done through specialized software, the OQ-Analyst, which provides therapists and clients with instantaneous feedback. The OQ-Analyst has been recognized by SAMHSA as an evidence-based practice (NREPP, 2008).

Five highly rigorous clinical trials using the OQ-45 outcome management system have demonstrated significant benefits. The first study (Lambert et al., 2001), posed the client-focused research question, "Does feedback on client progress improve outcomes?" (p.51). An experimental design of 609 clients and 31 therapists led researchers to conclude that providing feedback increased the duration of treatment and improved outcome. Twice as many clients in the experimental/feedback group achieved clinically significant or reliable change and one-third fewer were classified as deteriorated by the time treatment ended. When therapists received feedback about clients who were on track to a positive outcome, they progressed more quickly. Those clients headed toward a negative outcome remained with therapy longer and saw less decline or improvement in their status than the non-feedback/control group. The second study of 1,020 clients and 49 therapists (Lambert et al., 2002), replicated the 2001 study with similar results. Twice as many clients in the experimental group, who were monitored for progress, experienced clinically significant or reliable change compared to the control group. Additionally, fewer of these clients were characterized as deteriorating. Clients progressing positively did so with a similar number of sessions as compared to the control group.

In the third study, therapists ($N = 48$) used the OQ-45 and clinical support tools with 981 clients and found clients whose therapists received feedback stayed in therapy longer and had greater outcomes, with almost twice as many clients achieving clinically significant or reliable change, and fewer clients deteriorated (Whipple et al., 2003). In the fourth study, Hawkins et al. (2004) used the OQ-45 to test the idea of sharing feedback on the progress of therapy to both the therapist ($N = 5$) and client ($N = 201$) as compared to just sharing information with the therapist. The results of the analysis sustained the

hypothesis that providing information to both clients and therapists is valuable. The final published clinical trial to support the use of the OQ outcome system (Harmon et al., 2007) tested the impact of providing feedback and clinical support tools to therapists. They found that outcome was enhanced in statistically and clinically meaningful ways. This was achieved by therapists receiving information regarding their clients' ($N = 2,819$) progress along with a strategy for handling clients who were not progressing. Tracking outcomes, especially with clients who are showing no benefit or deteriorating, can increase the amount of therapy received and the likelihood of improved health (Hansen, et al., 2002). Finally, in a non-experimental study, Brown and Jones (2005) conducted a large scale investigation with a behavioral health managed care company and 7,000 therapists. Focusing on costs and quality insurance the project utilized a modified OQ-45 and concluded that focusing on individual clients' progress was an effective method to manage costs and that outcome data could be used to identify better performing therapists.

Treatment Outcome Package. The third well-developed outcome management system is the Treatment Outcome Package (TOP)(Kraus & Horan, 1997). The authors claim widespread use of the system, with over 15,000 therapists in seven states. The company overseeing dissemination is now Behavioral Health Laboratories. The adult outcome measure has been continually abbreviated, from 93, to 85, to now a 58-item, six-point Likert scale questionnaire. Psychometrics including test-retest reliability, discriminant and convergent validity, and criterion validity have been tested with satisfactory results (Kraus et al., 2005). The measure takes 25 minutes to complete with a reported 16 minute return rate, via fax, to the therapist (Kraus et al., 2005). The length of

time to complete and receive reports has been identified as a limiting factor, as compared to other outcome systems that provide immediate feedback via web-based applications (Lambert, 2009).

Partners for Change Outcome Management System. Partners for Change Outcome Management System (PCOMS) is the fourth, and most recent outcome system to be developed (Duncan, Miller, & Sparks, 2004; Miller, Duncan, Sorrell, & Brown, 2005). Building on the growing body of literature on assessing outcomes and devoted to empirically-derived clinical practices, the developers of PCOMS incorporated the robust predictors of therapeutic success into an outcome management system that partners with clients while honoring the daily time pressures of therapists. The early scholarly work established the reliability, validity, and psychometric properties of the two key measures, the ultra-brief Outcome Rating Scale (ORS) and Session Rating Scale (SRS) (Bringhurst, Watson, Miller, & Duncan, 2006; Cambell & Hemsley, 2009; Duncan et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). Specifically, the ORS's reliability or internal consistency, as measured by Cronbach's coefficient alpha, was .97, test-retest reliability at the second session was .80, and concurrent validity (when compared to the OQ45) ranged from .53 -.69 (Bringhurst et al., 2006). Reliability of the SRS, as measured by coefficient alpha, was .88, overall test-retest reliability was .64, and concurrent validity (when compared to the HAQ-II) was .48 (Duncan et al., 2003). ORS, a global measure of distress, is a four-item measure that takes approximately one minute to complete. Likewise the SRS, a global measure of alliance, is a four-item visual analogue instrument that takes a minute to complete. PCOMS is now available in a web based application (www.myoutcomes.com).

Two clinical trials and a trio of real-world implementations of client-focused research methodologies have demonstrated the benefits of client feedback with the ORS and SRS, PCOMS's brief outcome measures. Reese et al. (2009) found that when therapists and clients ($N = 148$), who attended therapy at a university counseling center or a graduate training clinic used the PCOMS, significant treatment gains were made over the comparison group. The feedback/experimental group showed about twice as much improvement as the control group. A nuanced finding from this study was that all clients seemed to benefit from using a continuous, or repeatedly administered, outcomes system, not just clients predicted to decline. In the second published study, Anker et al. (2009) worked to expand the use of client outcome management systems from individual therapy to couples therapy. The ORS and SRS tools were used and resulted in a moderate to large effect size of 0.50 for the feedback/treatment group. This study of Norwegian couples ($N = 205$ couples) found that feedback clients reached clinically significant change nearly four times more than non-feedback couples. The feedback condition maintained its advantage at 6 month follow-up and achieved nearly a 50% less separation/divorce rate.

In addition to the rigorous research published regarding the benefits of outcome systems, practical benefits have been measured by large organizations that have adopted the ORS/SRS methodologies to measure change in individual clients (Bohanske & Franczak, 2009). Claud et al. (2004) report cancellations and no-show rates dropping at their large Florida agency by 40% and 25% respectively. And clients involved in long-term therapy with no measureable benefits fell by 80%. These statistics had real impact on the agency, saving half a million dollars. In Arizona a large agency saw its therapists' productivity rise 33% while client no-shows dropped more than 70% (Bohanske &

Franczak, 2009). In Maine, another agency had similar success in implementing changes, reducing no-show and cancellation rates by 30% over three years. The challenging but ultimately positive experiences of these organizations transforming their service delivery systems provide a roadmap for others on how to incorporate client-focused research into daily practice.

AKQUASI. Outside of the United States two client-focused systems have been developed for outpatient and inpatient use (Beutler, 2001). Kordy et al., (2001) present a system developed and utilized in Germany and Europe which has many features unique to the European model for delivering mental health care. Because private companies insure only 5-10% of the German population, the German Federal Ministry of Health plays a very large role in health care and has a strong voice in implementing quality management efforts. Unlike the other systems, therapists can select from a wide variety of instruments to assess client change, based upon the specific needs and situation of the client. Clients are evaluated using a pre-post methodology, typically by the therapist, not the client's self report. A specialized software product (AKQUASI) assists with the data management and produces the feedback.

Clinical Outcomes in Routine Evaluation – Outcome Measure. In the United Kingdom, the Clinical Outcomes in Routine Evaluation – Outcome Measure, or CORE-OM (Barkham et al., 2001), which consists of 34 items, was designed as a valid and reliable tool to provide practice-based evidence for psychotherapy. This system is intertwined deeply with the UK's centralized national healthcare. The Department of Health in the UK is interested in evaluating the effectiveness of all aspects of healthcare,

and utilizes a software and web-based system offer technical support to facilitate scoring and analysis.

The six systems described above are the most advanced currently available to therapists. They all improve the scientific rigor over the use of simple outcome measures by incorporating the following common concepts: standardized measures, giving feedback to therapists, administering the measures repeatedly, utilizing client profiling and dose-response effect (Howard et al., 1986), and incorporating normalized cutoff scores.

Common Components of Outcome Systems. All of the outcome systems share a common goal of assessing the quality and effectiveness of service delivery, one client at a time. They do this by monitoring treatment-related change, identifying clients at risk of a negative outcome, and providing feedback to therapists (Beutler, 2001). They take the disparate use of outcome measures (Phelps et al., 1998) and provide the necessary support and education to encourage therapists to incorporate an outcomes system in their practice. There are several key concepts common to all outcome systems.

The source of outcome data is an important decision with clinical and practical implications. Outcome data can be collected from a variety of sources, including the therapist, client, significant other, or the payer (if a third party is involved). Each option presents its own set of advantages and disadvantages (Brown et al., 1999; Sapyta et al., 2005). Researchers have pointed out that clients, who may be experiencing significant impairment due to their mental health condition, are likely not to be accurate reporters in the moment or even retrospectively (Scholes, Turpin, & Mason, 2007). Bilsker and Goldner (2002) point out the lack of objectivity, or inherent bias when therapists are

asked to supply the outcome ratings. While unresolved, most outcome systems rely on client self report data to measure change. This approach is aided by the fact that most outcome systems are utilized in outpatient settings with adult clients.

Projecting the course of treatment is the ability to identify when therapy is not working and is another key component in outcome system methodologies. In a seminal article, Howard et al. (1986) demonstrated the relationship between dose, the number of therapy sessions, and response or the clients' outcome scores. The dose-response effect refers to the positive relationship between the number of therapy sessions and a client's outcome, with decreased benefit at higher doses (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009). The dose-response effect is based on averages and individual rates of change do occur. This research has parlayed into the development of more mathematically sophisticated concepts of recovery curves and patient profiling (Howard et al., 1996). These pioneering ideas, beyond the scope of this paper, allow therapists to predict a projected course of treatment based on the client's initial score on the outcome measure.

All of the systems use an index that allow therapists to identify the significance of the clients' change. The method systems used to measure change has continued to evolve (Newnham, 2010). Initially, statistical significance, the real differences between samples, was the exclusive marker utilized by outcome measures to determine if client change was real and not due to chance or error. This method carries the limitation of not indicating the importance or meaningfulness of an observed difference (Hansen et al., 2002). Effect size, an indicator of the magnitude of the observed difference in standard deviation units, was the second wave of measuring such changes. Effect size is a non-intuitive measure

and can be challenging for therapists to calculate and understand (Ogles, Lambert, & Field, 2002). While statistical significance and effect size are still used by researchers, the index of change now most frequently used by outcome systems is clinical significance. To determine if a client has made changes considered clinically significant two elements must be present: a cutoff score must be established in the measure (Lambert et al., 1996), and a reliable change index (Jacobson & Truax, 1991) must be created.

Standardized outcome measures of clinical severity establish a point that separates a clinical from a nonclinical population, the cutoff score. This point indicates a client's outcome score has moved from the clinical to nonclinical range (Asay et al., 2002). Through psychometric testing and comparisons to normative data (Jacobson & Truax, 1991), developers establish this score in their scoring system that demarcates functional versus dysfunctional, a normal population compared to a help-seeking one. Additionally, each outcome system also utilizes a reliable change index which permits users to know that client change is real, and not due to random chance or error. Once a client completes the measure for which a cutoff score and reliable change index have been established, clinical significance can be determined and feedback can be created (Lambert et al., 2005).

Another commonality in patient focused research methodologies is the use of feedback. Feedback is generated by the outcome measure – and shared with the therapist and in some systems the client. Frequency of giving feedback varies from one system to another. For example, the PCOMS system (Miller et al., 2005) recommends measuring change at each session, whereas OQ-45 (Lambert et al., 1996) users follow a different repeat measure design, collecting data at the first, third, fifth and then every fifth session.

Feedback is generated every three months when used with inpatient clients in European models (Slade et al., 2006). Therapists receive feedback in many formats: graphs, charts, a narrative describing the graphs and charts, and a message to the client. Depending on the outcome system different language is used in the narrative feedback message. Terms such as "reliable change," "recovered," "improved," "not on track," or "deteriorating" are used to describe an individual client's change status. These labels are made possible through the establishment of the cutoff score and related psychometric properties of the measure. Feedback can be general, targeted or personalized, while the content of the feedback can address risk/problem information, current clinical status, or change options (Schmidt et al., 2006). Ultimately, feedback triggers conversations between the therapist and clients about the need for further treatment, termination, or referral (Lambert et al., 2001).

Routine Practice - Survey Research

Research on outcome measurement for psychotherapy services has flourished in recent decades (Bickman et al., 2000; Chambless et al., 1998; Wampold, 2001); however, marriage and family therapy (MFT) research has focused almost exclusively on efficacy and effectiveness research (Addison, Sandberg, Corby, Robila, & Platt, 2002; Pinsof & Wynne, 1995). There are no published studies in the MFT literature from the client-focused (Howard et al., 1996), or as it is referred to in the MFT literature, process tradition (Pinsof &Wynne, 2000). Pinsof et al. (2009) are in the midst of developing an outcome system to utilize with couples and families; however, it has not reached the level of scientific accomplishment that the other systems have.

In the past two decades the client-focused research paradigm has launched several outcome systems; however, the literature about their actual use in routine practice is barren. The only data that alludes to therapists' continuous monitoring of outcomes appears from a current study. Chris Hall, University of North Carolina researcher, (personal communication, April 29, 2010) stated that preliminary results indicate researchers have found 3.6% of outpatient therapist surveyed ($N = 83$ surveys out of total 650 have been analyzed) are routinely collecting patient process data on outcomes. This research may give some initial idea of what is happening in actual practice regarding therapists routinely collecting objective data on client progress. Additionally, this preliminary data provides evidence from which to make a hypothesis in this study. While the current state of knowledge with regard to therapists' use of sophisticated outcome systems is exceedingly slim, what does exist is survey research that provides a window into the actual practices of therapists and how they utilize simple outcome measures. A review of the most recent published state and national surveys of MFTs unearthed only two studies asking about the use of outcome measures, whereas survey research with psychologists is more plentiful. As a result of surveys, data have been gathered on the prevalence of using outcome measures, who is using measures and why, and what type of measures are being used. The following findings were utilized in the construction of the hypothesis for this research study.

There is a dearth of information available about MFTs use of outcome measures, and inconsistent findings regarding the use of outcome measures by other mental health professionals. Johnson et al. (1999) conducted a survey of 122 MFTs about their use of research in clinical practice. About 40% of the (N = 49) therapists reported they

empirically evaluate the effectiveness of their clinical work. The only other relevant study (Beaton et al., 2009) surveyed MFTs inquiring: "Do you assess client outcome in your private practice or agency? If yes, how do you do this?" From this question the researchers reported that about 15% of the sample assessed client outcome. This survey data from LMFTs provides information from which this research study can conjecture a hypothesis. Beyond the MFT literature, Phelps et al. (1998) found 29% of their sample (N = 15,918) of psychologists utilizing some form of outcome measure. A survey of 539 therapists, primarily social workers and psychologists, serving adolescents found that 23% measure outcome (Bickman et al., 2000). Hatfield and Ogles (2004) conducted a survey in which they found 37% of psychologists reported using some form of outcome measure in their clinical practice. Finally, *Psychotherapy Finances* (2007) conducted a tri-annual survey of private practice subscribers and reported that only 3% of independent psychotherapists collected any kind of effectiveness or outcome data, indicating that when therapists do not have institutional support, measuring outcomes rarely occurs.

There are discernable trends on the characteristics of therapists who utilize outcome measures. Phelps et al. (1998) found that therapists' use of outcome measures varied by workplace setting, with the highest utilization (40%) from therapists at medical settings, 34% from academic and 35% from government-based settings. Furthermore, solo or independent practitioners reported the lowest rates of outcome measure utilization at 24%. The researchers also discovered that recently-licensed therapists were more apt to use outcome measures. Hatfield and Ogles (2004) found additional support for earlier findings and a fuller description of who is using outcome measures. Therapists more

likely to assess outcomes were younger, had a cognitive-behavioral orientation, worked more, did more child and adolescents therapy, and worked in institutional settings.

Despite diverse workplace settings there are themes explaining why therapists elect to use or not use outcome measures. Hatfield and Ogles (2004) reported the top general reasons therapists ($N = 874$) gave for declining the use of outcomes measures were practical issues, such as time or cost, and philosophic issues (e.g., relevance). Important reasons therapists gave to use measures were "tracking client progress" and "determining if there is a need to alter treatment." Conversely, the top two reasons for not using outcome measures were "adds to paperwork" and "takes too much time." In 2007, Hatfield and Ogles further analyzed their 2004 data on why therapists use outcome measures, and concluded that practical concerns were the most common reason for not using outcome measures. Additionally, the researchers found most therapists rated treatment related reasons as more influential than external pressures such as work requirements, marketing, or payer requirements. Johnson et al. (1999) discovered that the training the therapists had in research (coursework and experience) was a significant predictor of being involved in empirical evaluation of their own research. Finally, Clement (1996) and Morrison (1984) articulated the reasons why therapists in private practice rarely engage in measuring outcomes including: lack of funding, time constraints, insufficient modeling by peers and professors, client resistance, lack of skill in research design and data analysis, and lack of appropriate instrumentation.

When therapists do measure client outcomes they are using a very diverse collection of outcome measures, inventories, questionnaires, scales and tools (Hatfield & Ogles, 2004). Lambert, Hansen, and Finch (2001) reported on "literally hundreds of

available instruments" (p.160) from which therapists can choose. Froyd, Lambert, and Froyd (1996) found 1,430 different outcome measures being used in outcome studies (N = 348) published in 20 journals from 1983 to 1988. In a meta-analysis of 79 studies, Martin, Garske, and Davis (2000) found therapists using over 60 different outcome measures. A survey of 539 therapists, primarily social workers and psychologists serving adolescents, found that 23% utilized standardized assessment instruments (Bickman et al., 2000). Phelps et al. (1998) found 18% of their sample using standardized measures and 12% using non-standardized outcome measures. Phelps et al. (1998) further analyzed the data to find themes in the type of outcome measures being used. The most frequently used outcome measures were categorized as "miscellaneous standardized tests" at 9%, and "informal patient report" at 8%, indicating little consistency in a type of measure being used. This finding supports the conclusion that there is not one outcome measure being used widely by therapists in the United States. Finally, in 2004 Hill and Lambert reviewed measures used in assessing outcomes and found that only four specific measures were consistently used in studies published by the *Journal of Consulting and Clinical Psychology*: Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), Symptom Checklist- 90-R (SCL-90-R), and the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2). While popular with researchers, these measures are either too specific or too long to be utilized in client-focused research methodologies in routine practice.

Researchers Johnson, Sandberg, and Miller (1999) asked therapists (N = 124) who empirically measure their work about how, or what methods they used. About 21% of master's and 36% of doctoral level therapists reported using pre/post-test design

instruments to measure changes in client functioning. Beaton et al. (2009) discovered therapists assessed client outcome in a number of ways: periodic check-ins during therapy sessions, evaluation questionnaire, face-to-face verbal feedback at the end of therapy, and telephone follow up.

Bickman et al. (2000) compiled a list of 29 items that were most valued by mental health professionals ($N = 539$) working with adolescents. The top five were (a) history of maltreatment, (b) past and present youth stressors, (c) family functioning, (d) quality of parent-youth relationship, and (e) therapeutic alliance. Attempting to further understand how therapists judged client progress and how various factors influenced subsequent treatment decisions, Hatfield and Ogles (2006), found that verbal and written outcome measure information had an equal impact on therapists' ($N = 810$) judgment. This finding was surprising since the participants had indicated that verbal information was valued more. Additionally, capturing data that things were deteriorating for the client was more influential than receiving positive information from clients.

The survey research findings on the utilization of outcome measures in routine practice present some clear messages. The use of client-focused methodologies in routine practice is unknown. Moreover, most therapists are not utilizing simple outcome measures. Therapists who do use outcome measures share similar reasons for using them, yet have little consistency in the specific measures or methodologies used with clients. The specific hypotheses of this study of Iowa LMFTs were shaped based on the aforementioned survey research on outcome measure use.

Challenges

Challenges facing developers and proponents of sophisticated client-focused research methodologies are some of the same challenges supporters of simplistic outcome measures have faced the past 25 years. Brown et al. (2001) point out the prerequisites for successful implementation of a systematic outcomes program, including the need for: reliable, valid and easy-to-use outcomes measures; economical and user-friendly technology to capture data; a large normative sample of clients; empirically validated statistical models; clinical reports and other decision support tools; and therapists' acceptance of and participation in efforts to systematically improve outcomes.

The prerequisites are generally available, however, researchers are skeptical about the willingness of therapists to change their practice (to administer, score and graph client results with software). Aware of the low adoption rates of simplistic outcome measures, especially among therapists in private practice (Psychotherapy Finances, 2007), researchers are pessimistic that therapists are willing to make major changes in clinical practice in the foreseeable future (Lambert, Hansen, & Finch, 2001; Asay et al., 2002). Therapists historically have been slow to warm up to the idea of evaluating client process and outcome. Lambert (2009) stated, "The most significant problem encountered with outcomes management systems is therapist resistance" (p. 257). With prognostications such as this, it remains questionable if widespread adoption of client-focused research by therapists will occur.

With the inception of client-focused research in 1996, researchers and developers of outcome systems acknowledge the field is young, and full potential of client based research and tracking are just beginning to be explored in routine practice (Lambert,

Hansen, & Finch, 2001). Brown et al. (2001) put the developments into proper historical context,

> Psychotherapy research has given us more than a quarter century of valuable information on how to assess change associated with behavioral health treatment. Although the science of outcomes measurement might be judged to be relatively mature, the implementation of outcomes management programs...is in its infancy. (p.934)

In order to entice more therapists to implement routine outcome measurement practical issues such as additional training on the complexities of the task, logistical problems, and additional resource requirements would have to be addressed, likely by employers or professional organizations (Phelps et al., 1998). Hatfield and Ogles (2004) acknowledge that psychologists have unique training and not all mental health professionals may feel as comfortable or confident in the building blocks of outcome measures: testing, assessment, research, and statistics. They recommend that similar research be done with other mental health professionals.

One more challenge to outcomes measurement systems is contrary research evidence. While the overall support for implementing continuous feedback with clients is strong, there are studies, or parts of studies, that do not find significant benefit from the efforts to monitor treatment outcomes. For example, Schmidt et al. (2006) failed to find improvements in effectiveness as an impact of routine use of outcome measures with 61 clients. Slade et al. (2006) found no difference in outcome for the three subjective measures utilized with the 160 outpatients in the study. Further limitations of studies measuring the effect of feedback of treatment outcome draw exclusively from adult

samples, or disproportionately oversample women compared to the general population (Knaup, Koesters, Schoefer, Becker, & Pushner, 2009). In addition, most of the published research is conducted by the founders/creators of the instruments and methodologies which raises the issue of long term sustainability of the measures. Are the data, ideas and methods compelling enough for a second generation of researchers and therapists to adopt? These considerations may give therapists just enough credence to decline the use of outcome systems.

Summary

Client-focused research offers a relatively new paradigm for researchers and practitioners. It has contributed to the growth of several outcome systems in the United States and abroad, with more under development. The nascent effort has generated psychometrically sound outcome measures and sophisticated methodologies to measure client change. Initial research on the advantages of outcome systems has provided strong indications that such systems are beneficial to clients, therapists, and payers of mental health services (Lambert et al., 2005). Among the general population of therapists, including the sub-population of marriage and family therapists, no published survey research exists on the prevalence of using outcome systems, client-focused research methodologies. There are data on who uses outcome measures, why they use them, and what information is valued, yet survey research indicates that most therapists, regardless of discipline, do not regularly use simple outcome measures. Challenges to outcome measures being more widely implemented are well documented.

This study provides important, yet initial data about outcome measures used by LMFTs in Iowa. This study was conceptualized and developed as a result of a

comprehensive review of previous research. The research serves as the foundation for this proposed research study and establishes this researcher's epistemic warrant for the study.

Chapter 3

METHODOLOGY

The purpose of this research study was to explore the use of outcomes measures by Licensed Marriage and Family Therapists in Iowa. This research was conducted in a context where despite the importance of outcome measures little was known about the use of outcome measures by Iowa LMFTs and no data had been published about LMFTs' engaging in client-focused research methodologies. In addition to collecting basic descriptive statistics on demographic, practice, and outcome variables, this study sought to better understand the association among these factors. The research hypotheses capitalized upon and furthered existing research results and advanced knowledge. The results of this basic research can inform training efforts with the use of outcome measures in therapy.

Based on the literature review, gaps in the existing literature, and this researcher's clinical experience, this research study sought to expand knowledge by testing seven specific hypotheses and examining the demographic and practice patterns of LMFTs.

Hypothesis #1 - A minority (less than 50%) of LMFTs utilize outcome measures to assist in assessing outcome.

Hypothesis #2 - Of the LMFTs who use outcome measures, these measures are used with a minority of clients/cases.

Hypothesis #3 - Over the course of treatment, the frequency with which outcome measures are most commonly used is one time.

Hypothesis #4 - Continuous (at every session) measurement of outcome is practiced less than three percent of the time by Iowa LMFTs.

Hypothesis #5 - A minority of Iowa LMFTs are aware of any of the sophisticated client-focused outcome systems.

Hypothesis #6 - The reasons for using/not using outcome measures are similar to reasons given by psychologists on past surveys.

Hypothesis #7 - Non-users of outcomes measures are significantly different demographically from users in terms of age, length of licensure, number of child/adolescent clients, and practice setting.

Finally, since this study is the most recent examination of the Iowa LMFT profession, demographic and practice data were examined.

Participants

At the time the study was carried out, the Iowa Board of Behavioral Science reported that there were 174 MFTs licensed in Iowa by the Iowa Department of Public Health's Bureau of Professional Licensure; all 174 Licensed Marriage and Family Therapists (LMFTs) in Iowa were queried. The Board collects and maintains a limited number of parameters on the LMFT population. The three of interest for this study were: gender, age, and years of licensure. An important qualification was that Iowa did not begin licensing MFTs until 1993, 17 years ago. The present study consisted of a census administration of the survey instrument as the entire population of LMFTs in the state of Iowa was invited to participate (Fraenkel & Wallen, 2006). Sampling error and noncoverage error (Dillman, 1991) will be eliminated by the entire population having the opportunity for inclusion in the survey.

Instrumentation

The survey instrument, LMFT Outcomes Survey (see Appendix B), was created for this study based on a combination of past research (Beaton et al., 2009; Bickman et al., 2000; Hatfield & Ogles, 2004, 2007; Phelps et al., 1998). It consists of two parts. Part I includes eight questions total, a set of four basic demographic questions, and four practice questions. Part II includes seven questions regarding the use of outcome measures in therapy. Where possible, survey questions were phrased to match items in previous surveys. For example, two of the questions, reasons for using and not using outcomes measures were taken from Hatfield and Ogles' (2004) study. The self-report survey instrument consisted of closed-ended selection questions (e.g., multiple choice) and open-ended supply questions (e.g., short answer). One contingency, or follow-up, question was utilized to probe deeper. The survey was administered once. Fraenkel and Wallen (2006) described the importance of utilizing an instrument with strong validity. Given the procedures of this survey research, three threats to internal validity: mortality, location, and instrument decay were of minimal concern (p.411). Mortality was a nonfactor as the study was not longitudinal and participants were not lost. It was unlikely that the location where the surveys were completed was a threat since it was sent to participants' homes. Since the survey was brief it was also unlikely that respondents tired or were rushed so that instrument decay would be a concern. Whereas the construct and content validity of the instrument were important factors in ensuring the information obtained from the survey was useful (Fraenkel & Wallen, 2006). Making sure the survey actually measured what it intended to measure, and that the survey's content and format were consistent were addressed in multiple ways. The survey was carefully crafted with input from experienced survey designers, including the three members of the dissertation

committee. Content, construct and face validity, the likelihood that a question will be misunderstood or misinterpreted, were addressed by pretesting the survey (Fraenkel & Wallen, 2006) with three licensed mental health professionals. The feedback was overall favorable. One question was repositioned in the survey, and that same question was reworded to provide additional clarity.

Ethical Considerations

Participants were provided with an informed consent form about the study (Appendix A), which they signed as an acceptance of their willingness to participate. The form, which notified participants of their right to informed consent, confidentiality, potential risks and benefits, was approved by the Drake University Institutional Review Board (IRB) in order to protect the rights of research subjects. Prior to initiation of the study, this researcher completed the *Human Participants Protection Education for Research Teams* course, sponsored by the National Institutes of Health (NIH).

Procedures

In chronological order, this researcher promoted the survey in person by setting up a display and speaking at a luncheon at the annual Iowa state MFT professional conference in Des Moines, Iowa. Next, the researcher utilized the email distribution list of LMFTs belonging to IAMFT, the state professional association, to send an article about the upcoming survey to participants. This reached the email inboxes of approximately 73% of the total LMFT population (personal communication, Abbie Winter, March 5, 2009). Third, a tri-annual MFT association electronic newsletter, including a brief description of the coming survey instrument, was sent to the same IAMFT members. Northey (2005) recommended using mixed modes of contact with

participants to improve the return rate. Given the recently reported lower response rate for electronic surveys (Miller & Lambert-Shute, 2009), the actual survey was mailed out. Trudeau, Russell, de la Mora, and Schmitz (2001) surveyed all MFTs in Iowa ($N = 169$) through an initial mailing, reminder postcards, and a second questionnaire, achieving a 45% return rate. Other researchers surveying MFTs have obtained return rates of: 34.4% from a national survey ($N = 526$; Doherty & Simmons, 1996), 80% from a state-wide survey in Minnesota ($N = 76$; Simmons & Doherty, 1995), 64.2% from a state-wide survey in Utah ($N = 77$; Nelson & Palmer, 2001), and 32.3% from a national survey ($N = 116$; Rosenberg & Pace, 2006). Addresses were obtained from the Iowa State Licensing Board's website. Included in the survey packet was a consent form (see Appendix A), the survey instrument (Appendix B), a cover letter (Appendix C), a two dollar bill, and a return stamped return envelope. Dillman's (1991) suggestions to improve response rates have been incorporated throughout the procedures of the mail survey including: prior notice, follow-up, financial incentive, stamped return envelope, and cover letter. Two weeks after the mailing date a reminder post card (Appendix D) was sent to all LMFTs. Six weeks after the initial mailing this researcher concluded data collection and began data analysis.

Data Analysis

First, to gauge the representativeness of the survey respondents, they were compared to the population parameters (age, gender, years licensed) of Iowa LMFTs that were available from the Iowa Department of Public Health's Bureau of Professional Licensure (Table 1). This analysis permitted the researcher to make a claim on how representative study participants were compared to the known population demographics

of the entire population. Since the population's parameters were known, simple tests of significance determined if respondents were statistically significantly different from the population along the three known parameters. Quantitative data (age and year licensed) from the two data sets were compared using SPSS's t-tests for a single sample mean. A .05 significance level was used. This procedure compared the means of the two data sets and determined if differences were significant. Categorical data (e.g., gender) from the two data sets was compared using a chi-square procedure. If the two data sets were not different, then this allowed greater confidence for generalization to the LMFT population in Iowa.

Second, data were reported according to the descriptive nature of the quantitative research design. Categorical data (e.g., "gender") collected from responses was reported utilizing raw numbers and percentages. Items of this nature were represented visually in a table. This allows quick and visual understanding of the results. Quantitative data, representing variables measured along a continuum, such as age or the year licensed were tabulated, including the three measures of central tendency and standard deviation of each variable. Minimum, maximum and range were reported for quantitative variables. This basic descriptive data provided a basis to support or reject five of the six research hypotheses.

Third, data were analyzed according to the correlation nature of the study's design. Correlations or associations among LMFTs use of outcome measures and the other variables were analyzed. All demographic and practice survey questions/variables in Part I (questions 1-8) were compared to the outcome measure questions/variables in Part II (questions 9-11, 13-15). A correlation coefficient (Pearson r) was computed to

express the degree of relationship that exists between the continuous interval variables, such as age (Question 1) and percent of therapists using outcome measures (Question 10). Correlation coefficients are represented as a decimal, between -1.00 and +1.00 (Fraenkel & Wallen, 2006). A scatterplot graphically displayed the results. Chi-square, crossbreak tables and contingency coefficients were done for categorical variables, and graphically represented appropriately. The purpose of this correlational analysis was to discover associations among variables and provide data to support or reject the seventh hypothesis of this research project. The results assisted this researcher in understanding related variables, and perhaps lead to research on making claims of how one variable might predict another.

Reporting

Once the surveys were tabulated and the analyses conducted, results were shared with interested constituents. The Iowa LMFTs' privacy and confidentiality are highly valued and will be protected. Responses remained anonymous and any public dissemination of the research findings was done in such a way that individual responses were not personally identified with any data or findings. A follow-up article in the IAMFT tri-annual newsletter will be published. An electronic version of the complete dissertation is available on the internet at the conclusion of the entire research process, as is standard with all Drake doctoral dissertations.

Summary

The hypotheses and demographic and practice patterns of LMFTs were examined through a survey research study. All 174 LMFTs in the state of Iowa were invited to complete a carefully crafted survey instrument, the LMFT Outcomes Survey. The short,

self-report survey instrument was sent, followed by a reminder postcard two weeks later. Ethical research practices, including compliance with IRB, were conducted throughout the data collection phase and the entire research study.

Chapter 4

RESEARCH FINDINGS

Response Rate

One hundred seventy-four survey questionnaires were mailed out to Iowa LMFTs. Two questionnaires (1.15%) were mailed back to the researcher as undeliverable to the address. Four questionnaires (2.3%) were returned but unusable (left completely blank). Of the original 174 surveys mailed to Iowa LMFTs, 91 were returned and useable for a 52.3% response rate. This is an increased return rate compared to the 45% return rate achieved in the 2001 published study (Trudeau et al., 2001) of Iowa MFTs.

Population Comparison

For the variable Age, the values from the survey sample of the mean and standard deviation were 52.4 years and 11.44 years, respectively. The State of Iowa mean age for LMFTs was 52.29 years (Table 1).

Table 1

State of Iowa LMFT Population Parameters

		($N = 174$)			
Age (in years):		Gender		Years of Licensure	
Mean	52.29	Female	66%	Mean	11.83
SD	11.29	Male	34%	SD	5.76
High	81.00			High	17.00
Low	27.00			Low	0.00
Range	54.00				

The difference between the sample mean and the State mean was not statistically significant at the .05 level ($t = .116$, $df = 90$). For the variable Years Licensed, the values

from the survey sample of the mean and standard deviation were 11.4 years and 5.86 years, respectively. The State of Iowa mean year licensed for LMFTs was 11.83 years. The difference between the sample mean and the State mean was not statistically significant at the .05 level (t = -.676, df = 84). Categorical data (gender) from the two data sets was also compared, using a chi-square goodness-of-fit procedure. This test compared the percent of men and women in the sample with the percent of men and women in the population. The sample did have a higher percentage of women when compared to the population (64% v. 66%). However, the results of this analysis indicate that while the samples differed, there were no significant differences between the two groups of data on the variable of gender (x^2 = .634, df=1). Given these findings, all subsequent analyses were collapsed across gender, age, and years licensed. Further, it gave this researcher greater confidence to generalize from the sample of LMFTs to the entire LMFT population in Iowa across all variables.

Hypothesis #1: A minority of LMFTs utilize outcome measures to assist in assessing outcome.

Of the 91 Iowa LMFTs who returned the survey, 10 categorized themselves as not practicing therapy the past year. Of the LMFTs that actively practice therapy, 64% (N = 52) reported using outcome measures at least once in the course of therapy, whereas 36% (N = 27) reported not using outcome measures. This finding *rejects* the hypothesis that a minority of LMFTs utilize outcome measures to assist in assessing outcome. Results of this research study found that most (64%) active therapists report measuring outcome with most of their therapy clients, whereas all previous research found less than 40% utilization.

Hypothesis #2: Of the LMFTs who use outcome measures, these measures are used with a minority of clients/cases.

Users of outcome measures reported using them, on average, with 70% of their clients/cases at least once over the course of therapy. Therapists' use of outcome measures ranged from five percent to 100% of their clients/cases. The median was 80% and the mode was 100%. In general, most LMFTs surveyed reported using outcome measures at least once with most of their clients. This finding *rejects* the hypothesis that of the Iowa LMFTs that use outcome measures, these measures are used with a minority of the clients/cases. This finding is particularly noteworthy given the barren literature based on this nuance of outcome utilization. This research found that therapists actually measured outcomes with the vast majority of their clients.

Hypothesis #3: Over the course of treatment, the frequency with which outcome measures are most commonly used is one time.

Participants were asked to rank the frequency with which they typically use outcome measures. Among the 52 Iowa LMFTs who use outcome measures, two responses - "Intake and Discharge" and "Other" - tied ($N = 27$ each) for highest frequency. Ranking third was "Only at intake" which was reported by 13 participants. The most frequent explanations written in by therapists who marked "Other" were: "as needed," "every 3 months," and "every 4th visit." This finding *rejects* the hypothesis that over the course of treatment, the frequency with which outcome measures are most commonly used is one time. This research found that on average most therapists are measuring outcomes at least twice throughout the course of therapy. This finding is striking given the desolate literature base on this degree of outcome utilization.

Hypothesis #4: Continuous (at every session) measurement of outcome is practiced less than three percent of the time by Iowa LMFTs.

This question asked respondents to rank the top three frequencies with which they typically utilize outcome measures. Four of the therapists ranked "every session" as their top and only choice for the frequency of using outcome measures. This translates to 5% of all active therapists use outcome measures in a continuous manner. Six other respondents (7.5%) ranked "every session" as one of three frequencies with which they use outcome measures, suggesting use is intermittent rather than standard practice. This finding supports the hypothesis that a small minority of Iowa LMFTs are measuring outcomes continuously (at every session).

Hypothesis #5: A minority of Iowa LMFTs are aware of any of the sophisticated client-focused outcome systems.

Out of the 81 active therapists who responded to the survey, 47% ($N = 38$) reported being aware of at least one sophisticated outcome management system. COMPASS ($N = 22$) was the most widely known system, PCOMS ($N = 19$) was second, and the OQ-45 ($N = 13$) was third. This finding *supports* the hypothesis that a minority of Iowa LMFTs are aware of any of the sophisticated client-focused outcome systems and sheds light on an area with essentially no existing literature base.

All of the active therapists in the sample who reported using outcome measures took the time to identify outcome measures they have used in the past 12 months. Over 80 different measures were identified by the LMFT respondents, with a high of 22 measures listed by one respondent and a low of one measure listed by another

respondent. Many of the same measures were listed repeatedly. Some listed well-known measures (such as the Beck Depression Inventory); others listed EAP or insurance company sponsored measures. Still other LMFTs listed satisfaction surveys while others simply stated that they verbally review treatment plan goals with clients. The data summarized in Figure 1 show the type of outcome measurement LMFTs reported using.

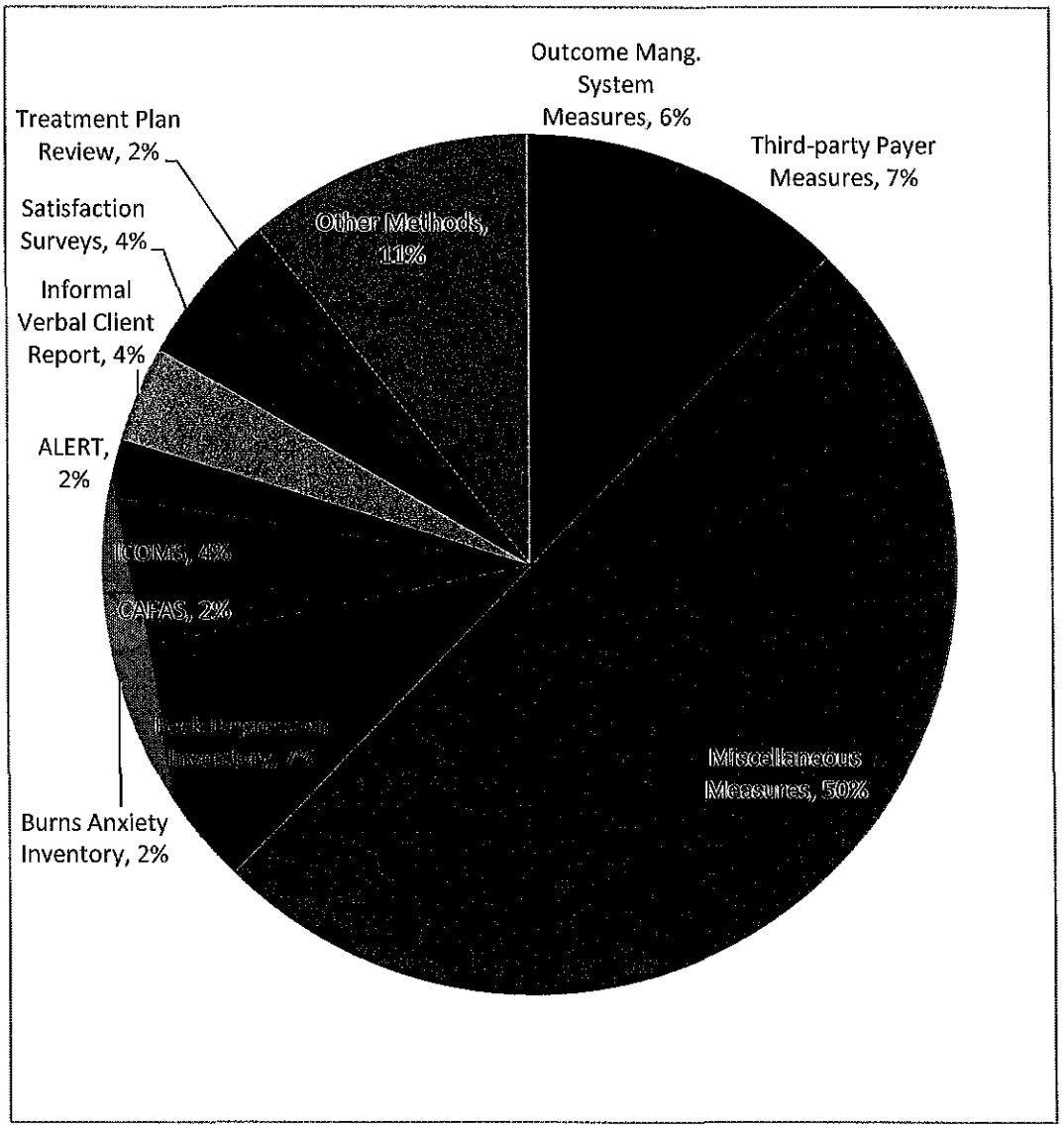

Figure 1. Types of outcome measurements.

Hypothesis #6: The reasons for using/not using outcome measures are similar to reasons given by psychologists on past surveys.

The strongest reasons LMFTs gave for using (Table 2) or not using (Table 3) outcome measures were similar to those given by Hatfield and Ogles's sample ($N = 874$) of APA psychologists in 2004.

Table 2

Reasons to Use Outcome Measures

Top 3 Reasons to Use (current study):	Psychologists' Top Reasons to Use:
1. Track client progress ($N = 67$)	1. Track client progress
2. Determine if there is a need to alter Tx ($N = 56$)	2. Determine if there is need to alter Tx
3. Determine strengths and weaknesses ($N = 37$)	3. Ethical Practice
	4. Determine strengths and weaknesses

The top three reasons to use outcome measures cited by LMFTs in this study were the first, second, and fourth reasons (out of 9) given by psychologists in the Hatfield and Ogle study (2004). Likewise, reasons not to use outcome measures given by the LMFTs were identical to the top three (out of 13) practical reasons cited by psychologists in the 2004 study.

Table 3

Reasons Not to Use Outcome Measures

Top 3 Reasons Not to Use (current study):	Psychologists' Top Reasons Not to Use:
1. Too much time ($N = 30$)	1. Adds too much paperwork
2. Too much paperwork ($N = 28$)	2. Takes too much time
3. Burden on clients ($N = 27$)	3. Extra burden on clients
	4. Feel it is not helpful

This finding *supports* the hypothesis that the reasons for using/not using outcome measures are similar to reasons given on past surveys by psychologists.

Additionally, when given an opportunity to state if outcome measures are clinically beneficial, 77 respondents (85%) took the time to write a response. LMFTs overwhelmingly said outcome measures were clinically beneficial. An analysis of

LMFT's qualitative responses revealed that "progress" was mentioned 22 times, and "effectiveness" and "feedback" were mentioned seven times in response to the open response question. A typical response in favor of outcome measures was, "Yes, they force you to take a purposeful look at the client's progress and help to determine if you need to do something different as a therapist who is treating them." Similarly, another LMFT commented, "Yes, helps gauge efficacy and determine if treatment is helping client meet goals of therapy." Of the 77 responses to this question, only five were mixed, such as, "To some degree – it provides a 'snapshot' but numbers alone don't really give the whole picture of a client's progress." Finally, there were three LMFTs who did not believe outcome measures were helpful; for example, "I don't believe they are that beneficial. My training and experience plus instincts work for me."

Hypothesis #7: Non-users of outcomes measures are significantly different demographically from users in terms of age, length of licensure, number of child/adolescent clients, and practice setting.

Chi-square tests of independence were conducted to see if any demographic or practice variables had a significant relationship to the key variable, use of outcome measures. The results indicated the relationships between use of outcome measures and each of the demographic and practice variables were not statistically significant at the .05 level, and thus appear to be independent of each other. This finding *rejects* the hypothesis that non-users of outcomes measures are significantly different from users in terms of age, numbers of child/adolescent clients, and work setting. Furthermore, a binary logistic regression analysis was conducted in SPSS to test if predictor variables (both categorical and continuous) would predict use of outcome measures (a dichotomous categorical

variable). The value of the Omnibus Test significance (.867) was not less than .05 and was therefore not significant. Thus, study findings indicate that users of outcome measures were not different from non-users of outcome measures.

While statistically significant differences were not found, several trends between the use of outcome measures and demographic/practice data were discovered. First, when this researcher batched respondents' years of work in ten-year increments, each group (1-10 years, 11-20 years, 21-30 years, 30+years) included more therapists who used outcome measures than therapists who did not use outcome measures. Furthermore, when the years of licensure were arranged together in five year increments, again, users of outcome measures outnumbered non-users in each licensed group. These findings suggested that Iowa LMFTs were using outcome measures regardless of years of work experience and years licensed.

When users and non-users were compared by highest degree of education, users of outcome measures outpaced non-users in all three categories: master's degree, doctoral degree, other. Finally, when cross tabulated with work setting, users outnumber non-users in every setting except one, hospital (see Figure 2). Data also indicated the likelihood of using an outcome measure is increased if LMFTs worked in an agency setting rather than private practice even though both settings had more users than non-users.

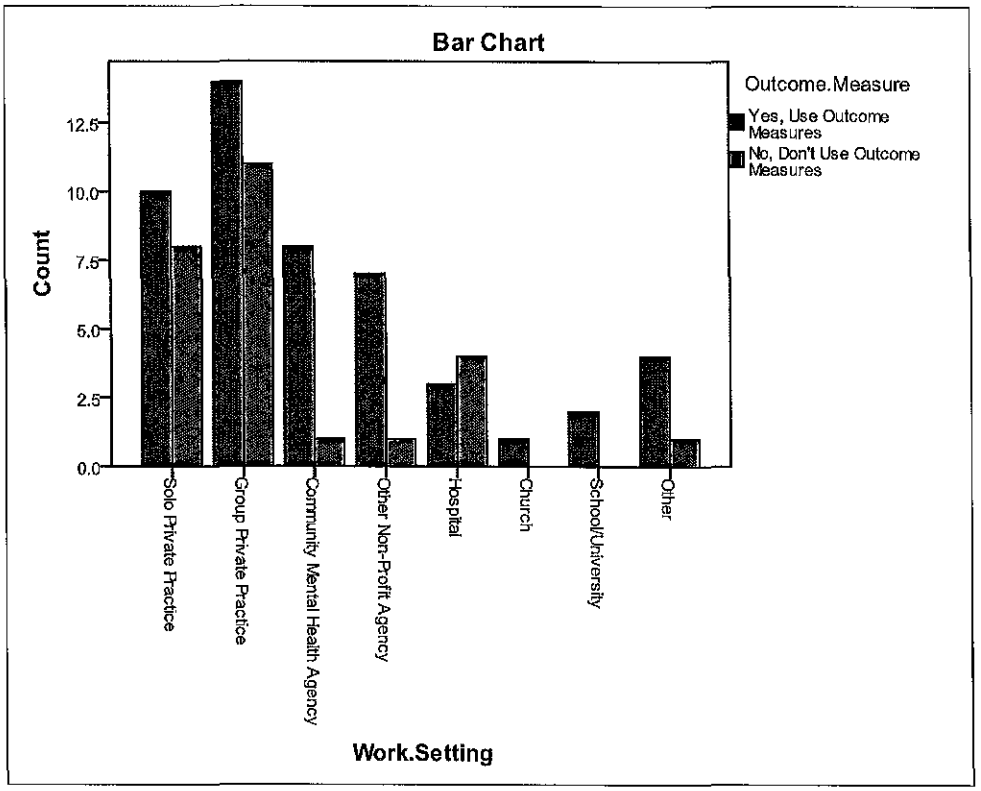

Figure 2. Outcome measure use v. work setting.

Iowa LMFTs' Demographic and Practice Data

The four demographic variables summarized in Table 4 are age, gender, highest degree, and race/ethnicity. The average LMFT in Iowa is a 52 year old, Caucasian female with a master's degree.

Table 4

Demographic Variables

($N = 91$)	
Race/Ethnic origin:	
African American/Black	0.00%
American Indian/Native American	0.00%
Asian or Pacific Islander	1.10%
Caucasian/White	98.90%
Latino/Hispanic	0.00%
Other	0.00%
Age:	
Mean	52.40
SD	11.44
High	79.00
Low	27.00
Range	52.00
Gender:	
Female	64.00%
Male	36.00%
Highest degree:	
Master's	65.00%
Doctorate	32.00%
Other	3.00%

While women comprised nearly 64% of the sample, they disproportionately hold fewer doctorate degrees to their male counterparts. Of the 58 women that responded to the survey, 28% ($N = 16$) have earned doctoral degrees whereas of the 33 men, 40% ($N = 13$) have earned doctoral degrees.

Three practice variables are represented in Table 5 including: years licensed as a LMFT in Iowa, total number of years of practicing therapy, and primary work setting.

Table 5

Practice Variables

Primary Practice Setting ($N = 87$):	
Solo Private Practice	21.80%
Group Private Practice	29.90%
Community MH Agency	10.30%
Other Non-Profit Agency	9.20%
Hospital	8.00%
Church	1.10%
School/University	2.30%
Not practiced in past year	11.50%
Other	5.70%
Years of Practice ($N = 90$):	
Mean	18.72
SD	8.47
High	39.00
Low	1.00
Range	38.00
Years Licensed ($N = 85$):	
Mean	11.40
SD	5.86
High	17.00
Low	0.00
Range	17.00

The average LMFT has been licensed in Iowa for 12 years, has been practicing therapy for 18 years, and works in a group private practice setting. (Note: 1993 was the first year LMFT were licensed in Iowa; a fact that informs the difference between years licensed and years practicing.)

When practice data and demographic data were compared, two findings stood out. First, when the variables *gender* and *years licensed* were cross tabulated, it was clear that women equal or outrank the number of men in each of the groups. Furthermore, the LMFT men licensed the longest (16+ years) outnumber the men in the other groups by two or three times (see Figure 3). Assuming that those LMFT men who are licensed

longer are also older, it stands to reason that at some point in the future the number of male LMFTs in Iowa will drop precipitously.

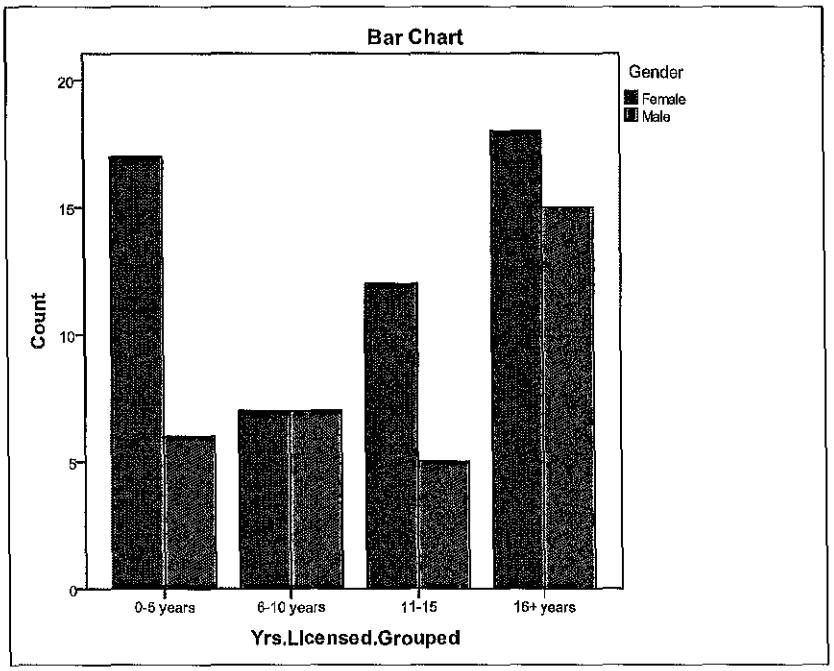

Figure 3. Gender v. years licensed.

When data were compared between highest degree attained and years licensed a second finding emerged. Iowa LMFTs with master's degrees outnumbered doctoral degree holders. Furthermore, LMFTs licensed the longest (16+ years) held more doctoral degrees than the other licensed groups by two or three times (see Figure 4). Assuming that those LMFTs with doctoral degrees who are licensed longer are also older, it stands to reason that at some point in the future the number of LMFTs with doctoral degrees in Iowa will drop sharply.

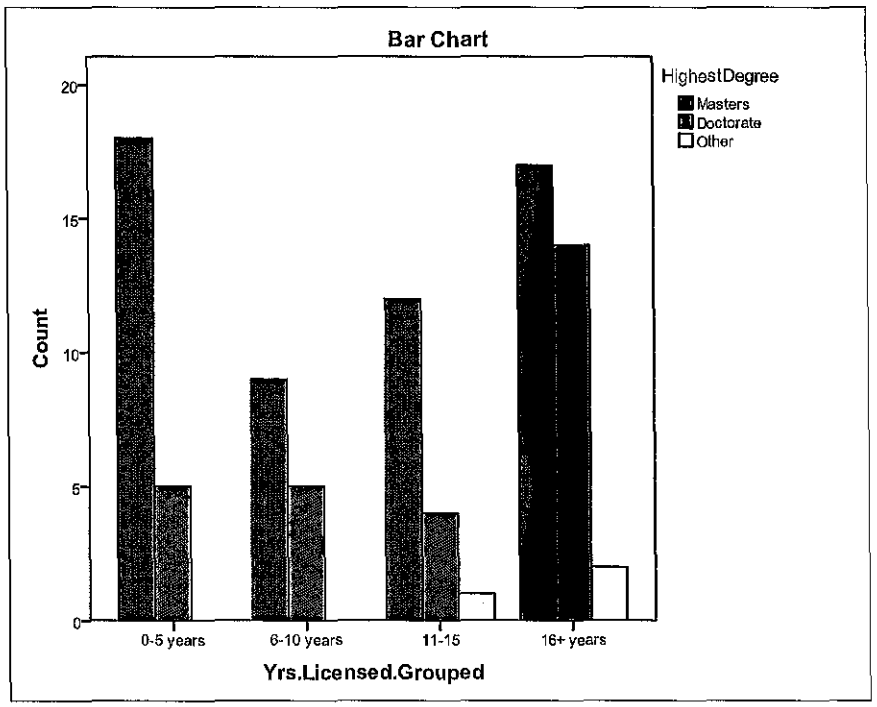

Figure 4. Years licensed v. highest degree.

Finally, LMFTs were asked what therapy modalities made up their clinical practice. The 81 "active" therapists in the sample engaged in five therapy modalities: 93% ($N = 75$) worked with individual adult clients, 85% ($N = 69$) reported doing couples/marriage therapy, 74% ($N = 60$) conducted family therapy, 65% ($N = 53$) did individual therapy with children/adolescents, and 16% ($N = 13$) conducted group therapy. While the survey responses indicated that most LMFTs were engaged to some degree in four of the five therapy modalities, some modalities consume a larger percent of the LMFTs' clinical practice time. Figure 5 describes the percent of time LMFTs spend providing service in each modality.

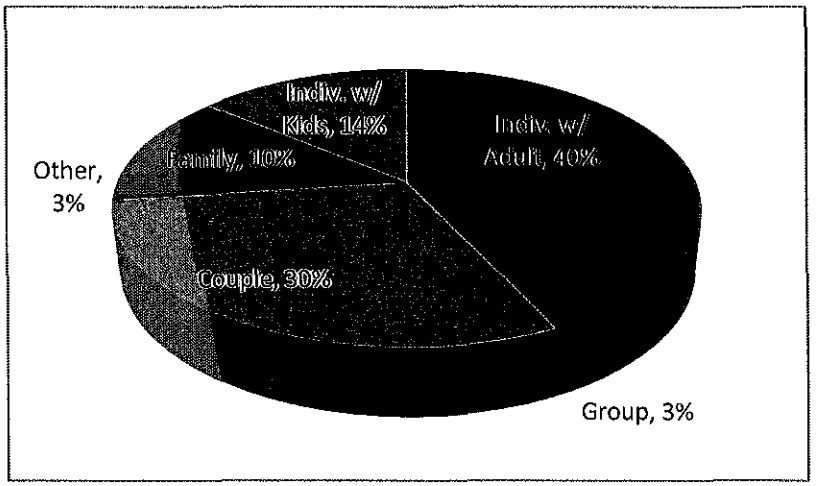

Figure 5. How LMFTs spend clinical time.

Summary

The research study obtained a good (52%) response rate. No significant differences were found between the sample and the population, suggesting results may be tentatively generalized to all LMFTs in Iowa. Results indicate that most LMFTs use outcome measures with most of their clients at least twice throughout the course of therapy. LMFTs overwhelming are positive about the use of outcome measures and reported their reasons for using them. Five percent of active therapists use outcome measures at every therapy session, and 47% are aware of newer outcome management systems. No significant differences were found between users and non-users of outcome measures. With regard to demographic and practice data of LMFTs, women outnumber men, and therapists' with master's degrees outnumber doctoral degree holders. Finally, LMFTs provide a mix of individual, couple and family therapy modalities with clients.

Chapter 5

SUMMARY, DISCUSSION, AND RECOMMENDATIONS FOR FUTURE RESEARCH

This study is a unique and important contribution to the existing literature in that it is the first to collect detailed data from LMFTs on their utilization of outcome measures. Whereas there are many mental health publications, books, journal articles, and commentaries written on the broad topic of outcome measures (Duncan et al., 2010), few studies have delved into the day-to-day experiences of therapists' utilization of outcome measures to the extent accomplished by this study. The purpose of this research study was to explore the use of outcome measures because (a) little is known about the use of outcome measures by Iowa LMFTs, and (b) no data have been published about LMFTs engaged in client-focused research methodologies. Finally, the research study, conducted via a mailed survey instrument, sought to better understand the association among demographic, practice, and outcome variables.

Discussion of Findings and Conclusions

Existing literature plus the newfound knowledge of this study led this researcher to eight key conclusions listed as part of the following discussion of the research findings on outcome measures. The area of client-focused research is highlighted, and the LMFT demographic and practice findings are discussed with three key conclusions.

Outcome measures. First, the utilization of outcome measures in the U.S. in routine therapy settings is increasing. An unexpectedly high number of Iowa LMFTs (64%) reported utilizing outcome measures in their clinical practice ($N = 52$). This represents the highest utilization ever documented in routine practice in North America.

Table 5 summarizes use of outcome measures by mental health professionals in recent surveys.

Table 5

Use Outcome Measures among Recent Surveys

Year	Study	% of Sample Using Outcome Measures
1998	Phelps, Eisman, & Kohout	29
1999	Johnson, Sandberg, & Miller	40
2000	Bickman et al.	23
2004	Hatfield & Ogles	37
2009	Beaton et al. (Canadian sample)	15
2010	Current Study	64

While some variability among surveys conducted over the past 12 years can be expected, the increase of usage from 1998 to 2010 (the year this study was conducted) may reflect changes in the field. Specifically, it appears that the use of third-party payer measures, state measures, and outcome management systems measures have likely increased over time. These types of measures comprised 17% of the measures currently being used by LMFTs in Iowa. For example, ICOMS is a state-wide tool/database promoted by the Iowa Department of Human Services for the past five years (Theresa Amstrong, personal communication, November 1, 2010). Additionally, Magellan Health Services, the payer for mental health services for Iowans with Medicaid, recently announced the required use of their two outcome measures (CHI and CHI-C) for all remedial services and mental health services received at block grant funded community mental health centers (Melissa Havig, personal communication, October, 26, 2010). These trends point to a real increase

in the use of outcome measures despite the fact that the studies in Table 5 indicate no discernable trends.

Second, many outcome measures advocates have lamented the lack of therapist enthusiasm to embrace outcome measure use (Bickman, 2008; Brown et al., 2001; Garland, Kruse, & Aarons, 2003). However, the fact that LMFTs who use outcome measures do so with 70% of their clients offers preliminary data and an encouraging sign on a previously unknown area of outcome measure utilization. Past surveys have settled for simply asking if therapists are using outcome measures, without probing further to ask how these measures are used in routine practice. The current study was the first to investigate this level of detail. Iowa LMFTs are consistently attempting to measure outcomes with most of their clients (at least once) during the course of treatment. This finding is likely due to a combination of factors, as indicated by survey responses, including payer and agency requirements.

Third, while most LMFTs are not practicing repeated outcome measurement with clients, increased frequency is one of the best ways to strengthen the scientific effectiveness of the service. Data from this study provide new information in an area of exceedingly slim published data; i.e., the frequency with which outcome measures are used. The most common frequency for outcome measurement reported by survey respondents was at "Intake and Discharge." When viewed positively, the survey results indicate some LMFTs are incorporating repeat measurement, a strong component of scientifically sound use of outcome measures (Beutler, 2001). However, most LMFTs are not practicing repeat measurement, and thus the documented benefits to clients of

frequent outcome measurement, identified by multiple research studies, are not realized (Asay et al., 2002; Reese et al., 2009).

In the current study, the finding that participants use outcome measure at intake and discharge is consistent with the top reason the LMFTs gave for using outcome measurement, namely to "track client progress." However, due to the wording of the survey question, findings from this study are difficult to compare to the results of Johnson et al. (1999) study of LMFTs. They found that 28% ($N = 14$) of therapists surveyed utilized a pre-posttest types of evaluation. Johnston and Gowers' (2005) survey of 186 psychiatrists and psychologists in the United Kingdom, a national health system with heavy government control, found 80% of respondents were collecting quantitative clinical measures repeatedly.

The fourth conclusion is there are strong reasons for therapists to consider adopting session-by-session use of outcome measures. Approximately five percent of active Iowa LMFTs reported continuous (that is, at every session) use of outcome measures. This new insight into a previously unknown area of routine use of outcome measures in the United States is only comparable to the preliminary results of Hall's 3.6% (personal communication, April 29, 2010). Routine outcome measurement was documented with 28% of a multidisciplinary United Kingdom sample in 2005 (Johnston & Gowers, 2005). In a field that experiences significant dropouts (Sharf, 2007), some researchers (Duncan & Miller, 2008) strongly advocate for the use of outcome measures at every session for multiple reasons. First, due to the poor predictive ability (Hannan et al., 2005) of therapists to detect which clients are deteriorating, measuring outcomes in each and every session provides a structure to identify which clients are failing and

respond accordingly (Newnham, 2010). Second, measuring outcome (and alliance) at every session has been demonstrated to significantly lower premature dropouts (Bohanske & Franczak, 2009; Claud et al., 2004). Third, a benefit of continuous measurement was demonstrated by research conducted by Anker, Duncan, Owen and Sparks (2010). Through the use of continuous measurement of outcome and alliance, researchers were able to tease out session-by-session factors, such as a couples' alliance with the therapist, which positively influenced treatment. This cutting edge research and knowledge gained would be impossible to gather if therapists utilized only a pre-post measurement methodology. A final reason to use outcome measures each session is based in an acknowledged complication with administering outcome measures only at intake and discharge; the reality that not all clients will return to complete the discharge measure (Ogles & Lunnen, 1996).

Fifth, there is a strong relationship among LMFTs who measure outcomes continuously and the use of highly developed outcome systems. This current research study is the first known study of any mental health profession to document the awareness and use of sophisticated outcome systems. Client-focused outcome systems have a shared commitment to monitoring change, identifying clients who are not progressing, and providing feedback to therapists (Beutler, 2001). Given the fact that these systems are a relatively new development (Howard et al., 1996), an unexpectedly high number (47%) of active therapists in the sample reported being aware of at least one sophisticated outcome management system. While respondents reported being cognizant of these systems, their utilization of any of these systems was much lower than their awareness. When LMFTs were asked to list outcome measures they actually used, eight respondents

listed outcome measures associated with two systems. Six LMFTs utilized outcome measures from PCOMS (ORS/SRS) and two used the OQ-45. When survey responses from these eight LMFTs were further examined for the frequency of outcome measures utilization, four indicated continuous (at every session) use. Although the number of therapists was small, the fact that five percent of active therapists in the sample were continuously using outcome measures from highly sophisticated outcome measurement systems is important, and serves as a marker in time to which future researchers can compare their findings.

The sixth conclusion is that therapists continue to use a combination of outcome measures that hampers the profession's ability to provide stakeholders with relevant data. The number of different outcome measures being used by LMFTs in the current study was high, with over 80 separate measures listed by respondents. Data from the study corroborated findings of multiple research studies (Froyd et al., 1996; Hatfield & Ogles, 2004, 2007; Mellor-Clark, Barkham, Connell, & Evans, 1999; Phelps et al., 1998) that indicate little consistency in the outcome measures being used by mental health professionals. While there were some measures that were listed more than others, none reached above seven percent utilization throughout the samples' responses.

Seventh, contrary to the findings of previous studies (Hatfield & Ogles, 2004; Phelps et al., 1998; Ventimiglia, Marschke, Carmichael, & Loew, 2000), in the current study, users of outcome measures were not different from non-users in terms of age, length of licensure, type of clients served, or practice setting. This finding suggests previously documented barriers to outcome measurement for private practitioners such as lack of funding, insufficient modeling by supervisors or professors, client resistance, lack

of appropriate instrumentation, and lack of skill (Clement, 1996; Morrison, 1984), may be waning. Perhaps more therapists, regardless of demographic and practice variables, are beginning to see the value to clients of measuring outcomes.

The eighth, and final conclusion, is that the topic of measuring outcomes in mental health is universal. From the United Kingdom (Johnston & Gowers, 2005) to Australia (Trauer et al., 2009) to the United States (Garland et al., 2003), clinicians and researchers around the globe are engaged in a quest for knowledge and improved clinical practice. Furthermore, mental health disciplines are similarly interested in demonstrating their effectiveness and meeting accountability demands set forth by payers, governments, and clients. For example, the APA's President (Bray, 2010) stated that psychologists will soon be required to demonstrate accountability for their work and to assess outcomes from their treatments (p. 362). The Council on Social Work Education has had conversations about defining "quality" in Master's training programs and how it could be more directly measured through the use of client-focused outcomes (Gambrill, 2002). Interest in outcome measurement encompasses research and services with adults (Gerdes, Edmonds, Haslam, & McCartney, 1996) and children and adolescents (Garland et al., 2003). The diversity of experiences and knowledge represented by those at the forefront of the movement to measure outcomes and improve services for clients is a tremendous resource for those clinicians, organizations, and governments looking to expand the use of outcome measures.

Client-focused research. Even though the newest research paradigm for improving outcomes goes by multiple names; e.g., client-focused research in psychology, process research in MFT literature, and the scientist/practitioner approach in social work,

it has a singular goal of answering the question, "Is this treatment working for this client?" Client-focused research has followed in the footsteps of efficacy and effectiveness research with all three striving to improve service to clients. Client-focused research was developed, in part, as a response to the concerns regarding the ability of psychotherapy to demonstrate its effectiveness and respond to broad concerns including high dropout rates (Wierzbicki & Pekarik, 1993) and lack of scientific rigor (Asay et al., 2002). Research suggesting that therapists are overly confident (Hiatt & Hargrave, 1995) but poor predictors of which clients will fail in treatment (Hannan et al., 2005), fueled the development of client-focused research methodologies.

Theoretically, the time and effort by Iowa LMFTs to measure outcomes has a goal of assessing the quality and effectiveness of the service. Survey results indicate that the majority of LMFTs were engaged in measurement of outcomes broadly defined. But only a small group of the active therapists (5%) incorporated the basic components of client-focused research methodologies, including: utilization of standardized measures, repeated administrations of the measure, identification of the clinical significance of change, and measuring change during treatment. These efforts that will help bridge the clinician-researcher gap (Johnson et al., 1999).

At this point it is unclear if rigorous measurement of outcomes will become standard practice or if methodologies that bridge the gap between science and practice will come to dominate clinical work in the future. As proponents of routine measurement of outcome have lamented (Bickman, 2008; Brown et al., 2001), changing the individual practice patterns is a steep challenge. Results of this research study suggested that a majority of therapists were making an effort to measure outcome although rigorous

measurement lags far behind. For educators, trainers, and managers attempting to implement outcome measures, simple or sophisticated, an ongoing obstacle is to acknowledge that the reasons for not using outcome measures are real. Using outcome measures takes time, increases paper/computer work, and when viewed as an added task, is a burden on clients. The challenge for those promoting outcome measures is to demonstrate that the benefits/positives of using the measures outweigh the practical feasibility concerns (Garland et al., 2003). Providing thorough and on-going training and support has been demonstrated with nursing and medical staff to improve implementation as has targeted training methods for clinicians who are at different stages of readiness to adopt new methods (Trauer et al., 2009). Bohanske and Franczak (2009) provide guidelines and instructions for behavioral healthcare leaders looking to transform their current practices to client-focused outcome measurement systems.

LMFT demographics and practice. The secondary focus of the current study was to collect practice and demographic data from Iowa LMFTs. Findings lead this researcher to three conclusions which should generate serious discussion among Iowa LMFTs and their state and national associations. First, as a group, LMFTs are getting older. In 2001, Trudeau's sample had a mean age of 43.83(N = 59, SD = 8.70). In the past nine years the mean age of MFTs has increased nine years to 52 years old. This fact presents a significant challenge to the Iowa profession. Unless a new generation of younger LMFTs joins the profession, this mental health group will see a considerable reduction in numbers since half (N = 87) of all current LMFTs will likely retire in the next two decades. Along the way, the LMFT profession will lose a substantial number of its licensed men and doctoral degree holders. These changes will be exacerbated with the

recent announcement that the only accredited master's program in couple and family therapy in the state at Iowa State University is being discontinued at the end of 2011 (personal communication, Megan J. Murphy, Ph.D., October, 26, 2010).

Second, the MFT demographics suggested the field is not keeping pace with the changing racial/ethnic diversity in the state. Iowa is a racially homogenous state with the vast majority of residents identifying themselves as Caucasian. The U.S. Census Bureau (2009) reported that people identifying as Caucasian make up 93.9% of the state's population. The sample of LMFTs in this study was 98.9% Caucasian. If recent population trends continue, the state's population will continue to diversify at a faster rate than the group of LMFTs. This is a concern insofar as some clients prefer therapists who look like or sound as they do. This may be increasingly difficult for LMFTs to match the demographics of Iowa residents. This is also a national issue for LMFTs, as Northey (2002) found 95% of his national sample of LMFTs identified themselves as Caucasian. A question for the field is: Why are people of color underrepresented among LMFTs, both in Iowa and nationally?

Compared to three recent surveys from other studies of LMFTs in Minnesota (Simmons & Doherty, 1995), the United States (Doherty & Simmons, 1996), and Utah (Nelson & Palmer, 2001), the Iowa LMFT sample consisted of a higher percentage of women, Caucasians, and older LMFTs. Compared to another national survey (Northey, 2002), the Iowa sample was composed of more women, but had similar ages (53 years old v. 52 years in Iowa), and years of experience (16 years v. 19 years in Iowa). The percentage of LMFTs with doctoral degrees in Iowa (32%) was comparable to the 34%

found in the national sample of Northey's 2004 survey but less than Utah's 52% (Nelson & Palmer, 2001).

While it is an oversimplification, it is interesting to note that this research study identified the "average" MFT as a Caucasian female, 52 years old, with a master's degree. This average therapist has been practicing therapy for 18 years, was licensed 12 years ago, works in a group private practice and spends the highest percentage of her time providing individual therapy to adults. Northey (2002) collected practice data from a national sample of LMFTs, including data on where LMFTs work and found that 50% of his sample worked in private practice and 26% worked in institutional/organizational settings. The Iowa sample was similar, with 52% working in private practice and 31% in institutional settings.

Third, it was interesting that despite being trained as marriage and family therapists, LMFTs in the sample spend a minority of their clinical time doing marriage/couple and family therapy. The 85% ($N = 69$) of LMFTs who work with couples, spend on average only 30% of their clinical time with this therapy modality. Likewise, the 74% ($N = 60$) of LMFTs who do family work devote only 14% of their clinical time to this therapy modality. Licensed Marriage and Family Therapists spend only 44% of their clinical time conducting marriage and family therapy. This is not a statistic unique to Iowa. After reviewing three studies of LMFTs, Nelson and Palmer (2001) concluded the percentage of time devoted to family and couple therapies as 46%, 35% and 43% respectively. One potential reason for this situation is that family and couple therapies are typically relational, not medical, services. In order to bill and get paid by third-party payers, the therapist must determine that the service is medically

necessary. Ethically, a therapist cannot bill for an important relational issue that is not a diagnosable individual condition/illness. The need for therapists to generate income and the reliance on billing third-party payers may be impacting the delivery of relational modalities of therapy.

Recommendations for Future Research

While this study advanced knowledge of the field by questioning more deeply the use of outcome measures in routine practice, additional questions remain for future study. A persistent challenge is comparing results of various studies of outcome utilization due to the semantic differences from one study to another. For example, in Beaton et al.'s 2009 study, Canadian MFTs reported "assessing outcome" using a number of methods; periodic check-ins during therapy, evaluation questionnaires, face-to-face verbal feedback at the end of therapy, and telephone follow-up (p.198). On the other hand, Hatfield and Ogles (2004) made a distinction between standardized and nonstandardized measures in their analysis. Ventimiglia et al., (2000) intentionally used a broad definition of outcome utilization to be inclusive of the multiple approaches in social work practice evaluation. Differences in how researchers operationalize concepts make direct comparisons across studies tentative at best. Future researchers should consider the benefits and costs of specifically defining outcome measures in future surveys to reduce the ambiguity of their results.

Furthermore, additional study is needed to address the fact that while therapists are using outcome measures consistently, they are not using them with every client over the course of treatment. Research questions could include: (a) What is occurring with the 30% of the clients/cases for whom outcome measures are not utilized? and (b) more

clinically focused questions, such as, How is the use of outcome measures aiding the client?

Finally, further study is needed to better understand the reasons for current practice. Exploring therapist training received in master's degree programs or in on-going supervision settings and examining workplace requirements could yield useful information, illuminate current practice, and perhaps accelerate the adoption of a scientific-practitioner mindset (Ventimiglia et al., 2000) with regard to measuring outcomes.

Implications

Mental health researchers, administrators, and association leaders attempting to increase the use of outcome measures could hold up the findings of this research study to reluctant adopters of outcome measures. Specifically, they could point to two findings, most therapists use outcome measures, and they use them with most of their clients. These important facts could be used in a campaign to normalize the current status of outcome measures use in routine practice in Iowa.

If 5% of LMFTs are measuring outcome at every session, then 95% are not. Trainers, supervisors, and graduate programs wishing to increase the utilization of outcome measures should address the top pragmatic concerns reported by therapists; namely, that outcome measures take too much time, increase (unwanted) paperwork, and put a burden on clients. Another persistent issue to address is ambivalence on the part of therapists. This apathy toward outcome measures is fueled by both therapists' confidence in their abilities as well as ideological opposition to the idea that quantitative measures can accurately measure the effectiveness of treatment (Garland et al., 2003; Ventimiglia

et al., 2000). Lebow (2010) suggests that session-by-session tracking of progress will likely soon be standard practice within the field of therapy due to the fact that the accountability demands of clients and third-party payers is not likely to abate. The implication of the current study and Lebow's prediction is that there is a lot of work to be done to move every session outcome use from its current five percent status to standard practice status. Therapists' own comments regarding outcome measures may prove instructive to behavioral health leaders who are looking to impact change positively rather than being the reluctant recipients of third-party outcome measure mandates.

The finding that therapists were overwhelmingly positive about outcome measure use should inform outcome measure training efforts in Iowa. The challenge to trainers, supervisors, and agency leaders may be not in persuading therapists to use outcome measures but to influence them to use them more frequently and with more clients. Highlighting and praising clinical examples of how session-by-session use of measures have benefited clients and therapists is likely to increase meaningful adoption of outcome measures due to increased confidence and skill. Ventimiglia et al. (2000) found half of the study's clinical social workers interested in attending workshops on practice evaluation.

The findings suggest Iowa LMFTs who measure outcomes continuously do so with the assistance of highly developed outcome systems. They have bought into and are putting into their own practice an idea more complex than simple outcome measures. A next step for researching the use of outcome measurement systems could be to explore the education and training settings of therapists to see if these systems are taught in school, in supervision while working on licensure, or in employment settings.

Furthermore, those wanting to implement outcome systems for their organization should pay attention to the level and methods of support for therapists using the systems. The systems that employ the SRS/ORS and OQ-45 both offer a rich collection of technical assistance and support (websites, training manuals, list-serves, etc) to therapists looking to measure the outcome of their services.

As a final point, the diversity of instruments, measures, questionnaires, and surveys intended to measure change presents multiple challenges for the field. First, the data from clients are only as good as the measure being used, and many respondents reported using nonstandardized measures. These measures have unknown and perhaps questionable reliability and validity, suggesting that therapists and agencies should move toward embracing standardized measures (Hatfield & Ogles, 2004). Second, it is nearly impossible for agencies that wish to promote their services to customers and funders to do so when there are no universally accepted measures being utilized by the agency. A hodgepodge of data, at best, is the result when disparate outcomes information is aggregated from individual therapists. Iowa's private nonprofit agencies, community mental health centers, hospitals, and even group private practices should seriously consider the benefits of selecting a set of agreed upon measures to avoid the measurement chaos and to be able to clearly communicate the benefits clients receive from the service. Ideally, this action will be initiated by therapists and administrators of clinical services rather than by outside forces (Lambert, 2009). Top down approaches, like the State of California's Performance Outcome Project, have had the mixed result of getting clinicians (psychologists, social workers and counselors) to comply with implementing outcome measures with clients, but 92% of those clinicians who are complying on a

surface level admit to never using the scores from the mandated measures in their clinical practice (Garland et al., 2003).

Limitations

There are several methodological limitations of this study that warrant further scrutiny. First, due to the study's descriptive nature of a relatively small number of participants, many interesting questions raised by the findings remain unanswered. Questions such as, Why did Iowa LMFTs report high use of outcome measures compared to past surveys? Are LMFTs using outcome measures differently than other mental health professionals in Iowa? These and other questions that seek to explain relationships and changes over time are not discernable given the methodologies employed in this study. A second limitation is the restrictive nature of survey research. While a variety of survey questions (e.g., multiple choice, ranking, short answer, etc.) comprised the LMFT Outcome survey, it is possible that the survey did not allow survey respondents the flexibility to share what was most important to them regarding outcome measure use. Third is the possibility of measurement error (Dillman, 1991). The nature of self-report surveys is that they rely on the strength of good construction and phrasing to illicit accurate and valid information. Another issue is participants' ability to accurately know or remember the response to a given question. While reporting one's age is a clear-cut matter, answers to questions that require therapists to estimate are likely to be rough educated guesses. Fourth, although anonymity was promised to respondents, social desirability may have impacted responses. The LMFT community in Iowa is relatively small, and survey respondents may have intentionally or unintentionally skewed individual responses to look better. Lastly, while the response rate was good (52%) and

survey respondents did not differ statistically from the population, it is possible that the roughly half of LMFTs in the state who did not respond to the invitation to participate in this research project differ from respondents in their demographics, practice, and/or use of outcome measures. While unlikely, this is a possibility, and the results should be at most tentatively generalized to all LMFTs in Iowa.

Summary

Regardless of the limitations of this study, its findings provide valuable information in many respects. First, the self-reported data on outcome measures provides an original and meaningful contribution to the literature. The findings indicate that most LMFTs utilize outcome measures, broadly defined, with most of their clients. The routine use of client-focused research methodologies in routine practice is in its infancy. Second, it provides the most detailed profile of the Iowa LMFT profession to date. The demographic data give a snapshot of LMFTs and challenge the profession to address pressing issues related to its future viability. The practice data provide a glimpse into the working life of LMFTs. Finally, the findings set the stage for further inquiry and provide rich information to those interested in conducting outcomes measurement training and continuing education for LMFTs in Iowa.

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Appendix A - **Consent Form**

You are being asked to participate in a research project to explore the clinical practices of Iowa LMFTs. The purpose of this research study is to learn about LMFTs use of outcome measures in clinical practice. You are being asked to participate in the study because you are one of the 172 LMFTs in the state of Iowa. Your participation will consist of answering survey questions on two aspects of your work as a LMFT. First, we are interested in documenting your thoughts and practices regarding measuring outcomes in your clinical work. Second, we are interested in gathering current demographic and practice data. If you choose to participate, this research study will involve completing this consent form, the enclosed survey, and mailing both back to the principal investigator. Completing the survey will take between 10 and 15 minutes. Your privacy and confidentiality are highly valued and will be protected. Your responses will remain anonymous and any public dissemination of the research findings will be done is such a way that your responses will not be personally identified with any data or findings.

It is not expected that participation will cause any risks or harm. Survey questions focus on your experiences and opinions of outcome measures. We are interested in your perceptions of these issues as an Iowa LMFT. However, if at any time you experience discomfort completing the survey please feel free to discontinue your participation in this study. Though there is no immediate benefit in completing the survey, a goal of the study is to gain a better understanding of the outcome measures used amongst LMFTs in Iowa. This information will be compared to recent surveys of other mental health professionals in the United States. Your participation is voluntary and may be discontinued at any time in the process.

If you have any questions or would be interested in the results of this study, please feel free to contact the Principal Investigator or Faculty Advisor:

Kevin Carroll, LMFT
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WDM, IA 20265
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Wade C. Leuwerke, Ph.D.
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This project was approved by the Institutional Review Board (IRB) at Drake University on TBD. If you have any questions you may contact the IRB at: irb@drake.edu or 515-271-3472.

Participant's Agreement:

I have read the information provided above. My signature below indicates my voluntarily agreement to participate in this research study.

_____ _____

Signature of Research Participant Date

Please mail Consent Form and LMFT Outcome Survey back in the enclosed stamped envelope.

Appendix B - LMFT Outcome Survey

Part I – Demographics & Practice Information

1. Age:_____

2. Gender (circle): 1 Female 2 Male

3. Circle your highest degree?
   1 Master's Degree (MA / MS/ MED)
   2 Doctorate (Ph.D., Ed.D., Psy.D.)
   3 Other _____

4. Circle your race/ethnic origin?
   1 African American/Black
   2 American Indian/Native American
   3 Asian or Pacific Islander
   4 Caucasian/White
   5 Latino/Hispanic
   6 Other_____

5. Year initially licensed as a LMFT in Iowa: _____

6. Total # of years practicing therapy: _____ years

7. Circle the primary setting where you practice?
   1 Solo Private Practice
   2 Group Private Practice
   3 Community Mental Health Agency
   4 Other Non-Profit Agency
   5 Hospital
   6 Church
   7 School/University
   8 Haven't practiced psychotherapy in the past 12+ months. (STOP survey – please mail back)
   9 Other _____

8. Approximately, what percentage of your therapy/clinical time do you spend with the following clients?
   _____% Individual with children/adolescents
   _____% Couple/Marriage
   _____% Family
   _____% Individual with adults
   _____% Group
   _____% Other_____
   100% (Total should add to 100%)

PART II – Use of Outcome Measures

9. Therapists measure outcomes with many tests, instruments, scales and inventories. They may be done via paper-pencil, electronically, or verbally. Measures may be completed by the therapist and/or the client. With this definition in mind, do you use outcome measures with clients? If so, which ones?

_____1 Yes, I do use outcome measures. Please list all used in the past year:

_____

_____

_____

_____

_____

_____2 No, I don't use any outcome measures (skip to question 12)

10. Considering all of your clients/cases, approximately with what percentage do you complete an outcome measure at least once in the course of providing therapy services? _____%

11. Which responses below best describe the frequency with which you typically use outcomes measures with a client/case? Rank your top three, with 1 being what you do most often.

_____1 Don't use
_____2 Only at intake
_____3 Only at discharge
_____4 Intake and discharge
_____5 Every session
_____6 Every other session
_____7 Other (specify) _____
_____

12. Do you believe that using outcome measures are clinically beneficial? If yes, please describe the benefit. If not, please describe your view of outcome measurement.

_____
_____
_____
_____
_____

13. Which of the following are reasons to use outcome measures? Rank your top three, with 1 being the strongest reason to use.

_____1 Track client progress
_____2 Comply with workplace
_____3 Comply with managed care/insurance
_____4 Business marketing
_____5 Other_____
_____6 Determine if there is a need to alter treatment
_____7 Determine strengths and weaknesses
_____8 Ethical practice
_____9 Research publication

14. Which of the following are reasons to NOT use outcome measures? Rank your top three, with 1 being the strongest reason not to use.

_____1 Not helpful
_____2 Too much paperwork
_____3 Too much time
_____4 Burden on clients
_____5 Interferes with autonomy
_____6 Client Refusal
_____7 Other_____
_____8 Do not know how to implement a strategy
_____9 Will be misused by others
_____10 Do not know how to interpret scores
_____11 Not enough resources (money, personnel)
_____12 Concerns about confidentiality
_____13 A simple measure distorts the effects of treatment

15. Please indicate if you are aware of any of the following outcome management systems. Check all that apply.

_____1 COMPASS (by Howard and colleagues)
_____2 Outcome Questionairre-45 (by Lambert and colleagues)
_____3 AKQUASI (by Kordy, Hannover, and Richard)
_____4 Clinical Outcomes in Routine Evaluation (by Barkham and colleagues)
_____5 Treatment Outcome Package (by Kraus and Horan)
_____6 Partners for Change Outcome Management System (by Miller, Duncan and colleagues)

THANK YOU for your time!

Please mail the survey and consent document back using the enclosed stamped envelope.

Appendix C – Survey Cover Letter

August XX, 2010

Dear Fellow Marriage and Family Therapist,

My name is Kevin Carroll and I am a LMFT in Des Moines and a doctoral student at Drake University. I am very pleased to announce a collaborative effort by the state professional organization, IAMFT, and Drake University to conduct a survey of the 172 LMFTs in the state of Iowa. LMFTs are a unique group of professionals in Iowa, and I hope you will take the time to complete the brief survey.

Increasingly, mental health professionals are being asked to demonstrate the effectiveness of their services. The primary purpose of this research is to gather initial data from Iowa LMFTs about how outcomes are measured in clinical work, while a secondary purpose is to gather current demographic and practice information about Iowa LMFTs and their work. Your privacy and confidentiality are highly valued and will be protected. The findings of the research will not only add to the knowledge base, but also enhance our collective efforts to advance our profession in Iowa.

Please take a few minutes to sign the informed consent document and the brief survey. Return both in the enclosed stamped envelope. Finally, I have enclosed a small gift as a token of my appreciation for participating in this project. Thank you for your time and consideration. LMFTs in Iowa are as unique as a $2 bill.

Sincerely,

Kevin P. Carroll

Appendix D

Kevin Carroll, LMFT
313 31st Street
West Des Moines, IA
50265

Stamp

Outcomes Survey
Thank you for taking the time to fill out the LMFT Outcome Survey – it is greatly appreciated!

If you haven't had a chance to complete and mail back your survey, please do so at your earliest convenience.

KevinpCarroll@hotmail.com